

THE MEDICAL JOURNAL OF AUSTRALIA

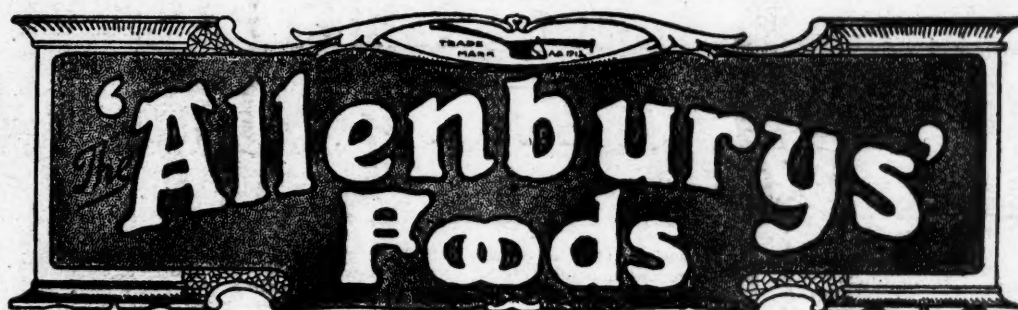
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SOME NOTES ON HEALTHY HOUSE BUILDING.¹

By James Nangle, F.R.A.S.,
Superintendent of Technical Education, New South Wales.

A house conveniently laid out, situated on a healthy site, soundly built to resist the weather, so placed with reference to the meridian that the sun will shine for a part of the day, at least, on each side throughout the year, and suitably finished and decorated makes a comfortable home. The description, however, applies to very few of our dwellings. Unfortunately, convenience of layout is too often sacrificed to convention, and sound construction to a craving for unsuitable ornamentation, whilst the smallness of the building sites and the generally bad direction of our streets make it frequently almost impossible to obtain the necessary amount of sunlight, even in this country of sunshine. The movement, well-established in England, and now gaining ground here, which has for its object the commonsense planning of towns, will help to bring into existence properly orientated streets and provide for a reasonable minimum size of building lot. There will probably, therefore, be better opportunities of properly placing a house and of having enough of land to secure plenty of light and air. If all had sufficient knowledge to avoid badly laid out streets and small building lots, land vendors would soon find that it did not pay to neglect attention to the essentials of health when planning the cutting up of areas of land for sale. It is astonishing how few know anything about the points that should be looked for when purchasing a site for a home. Generally the only guiding influence with the purchaser seems to be that the site must be near a railway station or tram stopping place. When he proceeds to have the plan of the proposed house made, he may find out that the lot is either too small or badly placed. Often, however, he never really knows of the cause of the baneful results that follow in having built a home that lacks healthy and cheerful conditions of site.

That the sun may shine on each wall for a little while at least during each day of the year, a house must be placed so that its external walls are out of parallel with the directions of the cardinal points of the compass. If the walls run north and south and east and west the south wall will have no sun for a considerable portion of the year, and rooms on that side will be unhealthy. In the latitude of Sydney, the sun at midday in midsummer is $10\frac{1}{2}^{\circ}$ north of the zenith, or point directly overhead, although it rises and sets 29° south of east and west respectively. A south wall, consequently, would get sunlight in the morning and evening in summer. At the equinoxes, however, the sun rises due east and

sets due west, therefore a wall facing south would have the sun shining along it at sunrise and sunset, but the sun would not get in at the windows. As the equinoctial sun rises higher in the heavens during the day, it gets north of the line from east to west, and at midday is 34° north of zenith. After the autumn equinox and before the spring equinox, the sun rises north of the line from east to west. At midwinter the sun rises 29° north of east, at midday it is $57\frac{1}{4}^{\circ}$ north of the zenith, and it sets 29° north of west. A wall facing south will, consequently, have no sunshine, either on or along its

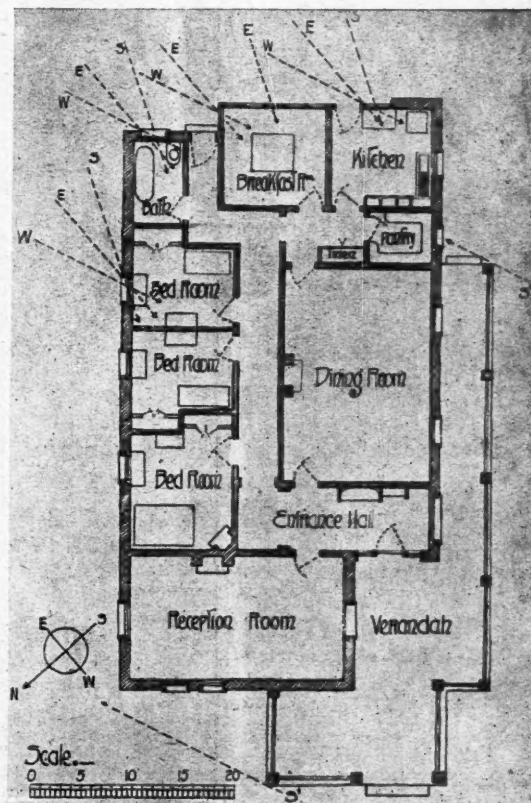


Fig. I.

face from the autumn to the spring equinox. If, however, the building be so placed that the corners are opposite to the cardinal points of the compass, the walls (if the building be rectangular) will be diagonally placed, and each will get some sunlight during each day. Figure I. shows plan of a small house diagonally placed with reference to the meridian, or the north and south line, and the lines marked S.E.W. show the sun's rays at midsummer,

¹ Read at a meeting of the Public Health and Kindred Science Section of the Royal Society of New South Wales on September 12, 1917.

equinoxes and mid-winter respectively. From the foregoing it will be clear that with streets running north and south, and east and west, houses on small lots cannot be diagonally placed, and that the rooms of the south sides will get no sun for one-half of the year. North-south and east-west streets are not objectionable if the building lots are large enough to allow of the proper placing of the houses. Lots sufficiently large to allow of this being done are too expensive under the present system for the average man, and the consequences are that in such streets the fronts of the houses are placed parallel to the street direction. Under the circumstances, all that can be done is to warn purchasers of land against buying lots in such streets.

Another point to be considered as of equal importance to sunlight is that of the nature of the site itself. Low or swampy land should be avoided. The best districts are those having gentle undulations. A site in such a district fronting a street of proper direction, and with the slope towards the east or north and down to the street would be ideal. A slope to the front rather than to the back is recommended, since it makes surface drainage an easy matter; moreover, the steps will be at the front instead of at the back of the house, an important consideration, since more than one or two steps at the back add too much to the labour of the women-folk engaged in the home duties. Preferably the site should be composed of sandy or gravelly soil, since these materials bear the weight of a building well, and do not shrink or swell, and, being porous, they do not hold moisture. Clay bears weight well, but does not allow of rapid percolation of sub-surface water. This material also shrinks and swells with change of weather, and causes cracks in the building.

From the health point of view the disposition of the various rooms in a house is a very important matter. The sun's rays must have access to bedrooms. Preferably the rays should enter in the morning, but at the latest not after noon. The summer afternoon sun is too hot, and leaves the rooms too warm for sleeping in comfortably. The bathroom should also have the morning sun. A bathroom into which the morning sun cannot enter is far from being as pleasant on a winter morning as it should be. At any rate, sunlight must be let into the room some time during the day, and the afternoon sun is better than none at all. The kitchen is a room in which someone is nearly always working, and should have the sun's rays, but in the morning rather than in the afternoon. It is very pleasant, indeed, and cheers the one getting early breakfast on a winter's morning to have the early morning sunlight streaming in. Even small houses have a breakfast or morning room. Such a room loses much if shut off from the early morning sun. The reception and dining rooms may be on the south-west side. It is desirable, however, in order to guard against the hot summer afternoon sun, that the rooms on the south-west and north-west sides should have the protection of a verandah. In summer the rooms can be shielded with verandah blinds during the hottest part of the afternoon. The plan (Fig. I.),

whilst not being given as the best that can be done in house planning, shows various rooms disposed so as to get the sun's rays, as suggested. In these notes, the name house is intended to apply to structures of one or more stories, of the kind within the means of most men. One-story houses, or cottages, as they are called in this country, are now generally used by the average man, and, all things considered, they are the best, because they are easiest to manage. The services of one maid is the most that the wife of the ordinary man can have, and often enough even this help cannot be afforded. It therefore becomes a matter of the utmost importance to reduce the housework to the smallest possible amount. Whilst a cottage covers more land than a house of two stories of the same room space, the stair in the latter greatly increases the labour. To a mother with four or six children the running up and down stairs all day is so tiring as to wear her out completely. The matter is made much worse than it need be by badly-designed stairs. Sketch A (Fig. II.) is a plan of a

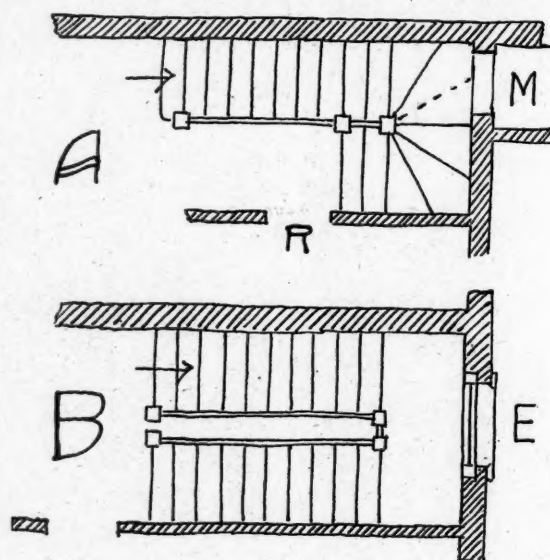


Fig. II.

stair having one long flight, winders (or triangular steps) and a short flight. This kind of stair, which is by no means uncommon, has no window to light it, and one passage leads on to the winders. Added to those defects, it is usually found that the height of each step is excessive. A woman using such a stair many times a day is liable to a painful and severe disease well known to doctors. A good stair should have short flights, landings instead of winders, and the gradient should be such that the height of each step, multiplied by its width, will be 66. A stair window of ample area should be provided to light the stairs. The plan of what a stair should at least be is given by Sketch B in Figure II. This stair, without winders, has a window over the landing and equal flights. The great difficulty seems to be with the majority of two-story house builders

that the necessary space is grudged to this very important part.

It should be remembered in planning a house that a large room without proper ventilation is not healthy, whereas a small room properly ventilated may be quite so. Wall air outlets, as near to the ceiling as possible, on opposite walls are efficient; but such a system of ventilation may be made much more so if inlets be provided, and so placed, that the incoming stream of fresh air from outside enters the room at about six feet from the floor. Such inlets should be provided with flaps to cut off inflow in cold weather. The outlets near the ceiling should never be closed in this climate. Rooms may also be large, well-ventilated and yet uncomfortable and unhealthy if fireplaces, windows and doors are not carefully placed. In bedrooms, windows should be placed opposite doors, so that a draught does not pass over the bed or beds. In any room a door should not be at the side near a fireplace. Spaces should be arranged when putting in doors and windows that furniture may fit, and in bedrooms wardrobe spaces or clothes cupboards should form part of the building. Fireplaces should be put on internal rather than on external walls. When on an outside wall part of the heat is radiated outside and lost. Another fact worth noting is that chimney-stacks from external wall fireplaces are more costly to build than those which come from fireplaces so situated that the stacks leave the roof at the ridges. Figure III. shows the difference in this re-

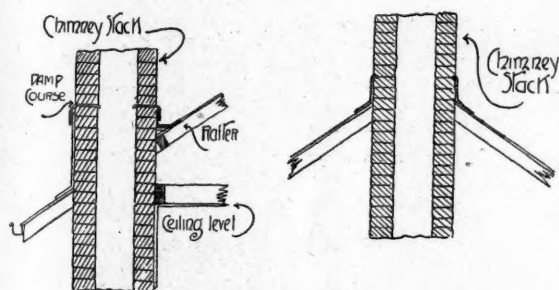


Fig. III.

spect. The sketch on the left-hand side is a section of a stack from a fireplace on an external wall. It will be observed that it has to have a gutter at the back of it, and a damp-course set in at a level just above the gutter. If the damp-course be omitted, the damp from rain soakage will descend and cause the chimney to leak inside the room and the ceiling to be damp. The stack is necessarily long, because the top of it must be level with the ridge, and must be finished to look well, and this will mean expenditure of money. The sketch on the right-hand side shows a stack from a fireplace on an internal wall. It will be noticed that being at the ridge a gutter is not necessary, neither will a damp-course be required, because the distance from the ridge to the ceiling is too great to allow of soakage

getting down so far. The relationship of the kitchen to the dining room should have the greatest consideration. Careful observation has shown that every twelve inches of travel between the kitchen and the dining room for meal service means about one mile per annum. So that if there were five feet of travel beyond what should be planned it would mean five miles per annum of unnecessary walking for a woman each year. The kitchen should be as near as possible to the dining room, but so arranged with small intervening lobby that kitchen smells cannot invade the house.

One of the most noticeable defects of house building in this country is in roof design. A roof of good pitch and of either slate or tiles is always put over the front portion of the house. On the back part, however, it is generally very flat and of galvanized iron. Figure IV. shows a diagram section of a common arrangement. Not more than about twelve inches intervene between the kitchen ceiling and the iron roof over it. On a summer's day the blazing sun beats on the roof, and the heat is conveyed to

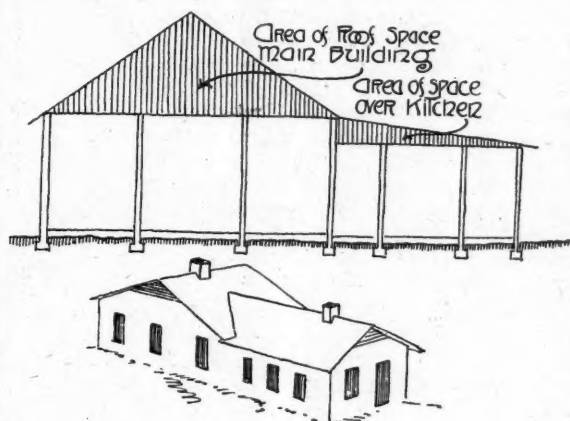


Fig. IV.

the ceiling, making the kitchen like a furnace. It has been already observed that in the ordinary house the kitchen is one of the rooms most in use. Heated like a furnace, it becomes intensely enervating, and must affect the health of anyone engaged in it. Over the kitchen part, just as over the front of the house, a roof of good pitch should always be built. The perspective sketch in the lower part of Figure IV. shows such an arrangement of roof. Provided that the rafters be covered with one inch boarding and laid with felt or building paper prior to the galvanized iron being put on, the latter is a very good form of roof covering, if appearance is not a matter of importance.

The construction of the house must be of a substantial character if it is to be healthy. All money spent on ornamentation, such as columns, cornices, pediments, mouldings and wall decoration will not only be in bad taste, but the shell without the sub-

stance, if the foundations, walls, floors, roofs and other essential parts of a good house are wanting in quality of material and workmanship. Unfortunately in most houses money is spent in various forms of ornament and decoration which, while being wholly unnecessary, is obtained at the expense more or less of good construction. Ruskin epitomized the whole matter when he advised builders to "ornament construction rather than to construct ornament." By this he meant that a building, be it small or great, will only be architecturally good when its essentials in construction are made as good and as beautiful as possible, and that all ornamental features which are not really some essential part of the building are out of place, and consequently in bad taste. The Editor of the *British Architect*, recently writing on the subject of small home building, said that "All the simple virtues—breadth, quietude, solidity, picturesque expression, and even dignity, are possible in cottage building. The great and cardinal qualities of real architecture may be there too." The builder of a small home, with such authorities to guide him, may therefore safely make up his mind to have a thoroughly sound construction, and to finish the exposed parts, both internal and external, as simply as possible. By so doing he will be right on the question of taste, and safe on the all-important question of health.

One of the earliest questions that will arise when considering the construction will be as to whether the walls are to be of timber, or of brick or stone. Timber walls make a dry and comfortable house, but require a great expenditure to keep in order. Danger from fire is also, of course, greater; but this can be much reduced if the internal wall surfaces and ceilings are plastered on steel lathing or covered with fibrous plaster. The great defect, however, of timber houses lies in the large amount of covered-in spaces between weatherboards and plastering or other linings. These spaces are receptacles for dust, and as such are bad. On no account should timber houses be lined with lining boards. Lining boards produce insanitary conditions, since it is practically impossible to keep dust and filth out of the crevices between the boards. Brick walls are good, provided they are built with a two-inch cavity. There is no need to fear loss of strength due to the cavity, for it can be shown that, provided a sufficient quantity of metal ties of some good form are used, a wall composed of $4\frac{1}{2}$ inches of brickwork with an intervening cavity of 2 inches making a total through of 11 inches is stronger than a solid 9-inch wall. Care must, however, be taken to keep the cavities and ties clear of mortar droppings, and to put trays of lead or other suitable material under all window sills, and to put a lead gutter in the cavity immediately over each door and window opening. Damp patches over and under windows and over door openings are due to omission of these details, so vital to good cavity wall construction. An 11-inch cavity external wall is all that most small one-story house builders will be able to afford, and though if well-built it will do, it is nevertheless hardly what can be called good construction. A 16-inch cavity wall, that is 9 inches of brickwork

inside, 2 inches of cavity, and an outer $4\frac{1}{2}$ inches of brickwork makes the proper job. All brick walls should have strands of galvanized iron built in right round, at levels, under window sills and over window arches. Nothing is so effective in helping to prevent cracks as this galvanized iron binding.

Cracked walls are not only unsightly, but the cracks let in the damp, and otherwise are receptacles for dust and filth. A well-built brick wall will stand without cracking, provided that it has plenty of galvanized iron binding and that it has good footings. The footings should be directly under the walls, that is to say, they should project equally from each face of the wall. Clay abounds in the Sydney district, and by its shrinking and swelling is the cause of most of the cracks seen in the walls of our houses. The ill-effects of the movement of the clay can be avoided by sinking the footings below the levels usually effected by seasonal changes. About three to four feet down from the surface to the bottom of the footing will generally be found sufficient.

One of the most prolific causes of disease resulting from damp houses lies in the faulty ground-floor levels and badly-placed damp-courses. The level of the ground, both inside and outside, should never be higher than $19\frac{1}{2}$ inches below the under side of the floor joists at the place where the floor is nearest the ground. This would seem to be an easy condition to observe, yet it is surprising to find how often one part of the ground floor is put nearer to the ground than this. In fact, sometimes one finds the ground floor at one part of the house some inches below the level of the ground outside. This kind of fault is due to difficulties arising out of a sloping site. The ground floor is put near to the ground at the upper level, so as to avoid expense in foundations and steps by the height of the floor above the lower level. Such a mistake should on no account be made, because the damp-course in the wall cannot be effective. Damp will rise in the wall and the floor timbers and will rot. Sketch E (Fig. V.) is a

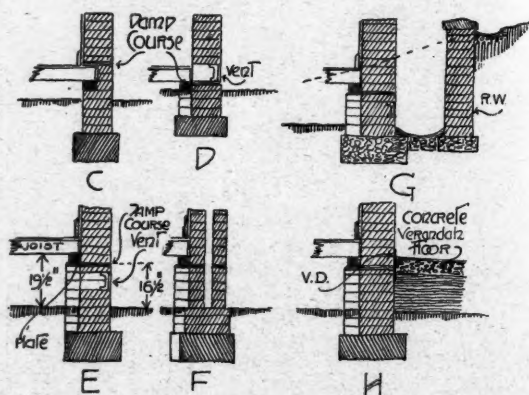


Fig. V.

section showing proper minimum levels of floor timbers, and the proper level of the damp course. It will be seen that the damp-course is put at a level just under the timber wall-plate carrying the ends

of the floor joists. The level of the damp-course above the ground outside should never be less than 16½ inches. If lower the rain beats up from the ground and wets the walls above the damp-course, and causes rising damp in the wall, which, even if only periodic, is nevertheless dangerous. Examples of damp-courses placed at incorrect levels are shown in Figure V. At C the damp-course is above the floor joists, and will allow of the latter getting damp and rotting. At D the damp-course is right with regard to the floor timbers, but too near to the ground, with the result that the wall above it becomes wet, and damp will rise. The proper position of the ventilators under floors is shown at E (Fig. V.). These vents should be nine inches by six inches, and two at least should be put into the external walls under each room, and be so placed that they are in opposite external walls. Openings should be put in intervening cross walls, so that a through current of air will flow. Sketch F (Fig. V.) shows relative positions of floor timbers and damp-course in a cavity wall. The special point of the sketch is, however, to show that the damp-course must not be carried across the cavity. If this be done, the mortar droppings during the building of the wall will accumulate on the damp-course and provide a means of conveying damp from the outer to the inner wall. Sketch G (Fig. V.) shows the arrangement necessary, where, as is sometimes the case, it is absolutely impossible to avoid having the damp-course lower than the natural slope of the ground. The dotted line shows the natural slope. The ground should be excavated so as to allow of the conditions as to space under floor timbers and outside height of damp-course illustrated in Sketch E being fulfilled. A retaining wall, R.W. in Sketch G should be built at a distance of not less than nine inches away from the outside of the house wall. At the bottom of the space between the house and retaining wall, a concrete gutter should be formed with sufficient fall to drain rain and soakage water. Nothing less than this arrangement will provide for means of ventilating the space under floors and keeping the lower walls dry. The home-builder is, however, cautioned to avoid, if at all possible, the necessity for adopting the arrangement. Sketch H (Fig. V.) shows a method of avoiding a kind of trouble that is often met with. The sketch shows a section of footing and lower part of an external wall, with portion of concrete floor of a verandah. Usually the space between the ground level and the concrete floor is filled up with clay or some similar kind of material. To make a suitable height of step from the verandah to the house floor, the level of the concrete will be higher than the damp-course, with the result that unless a vertical damp-course be put in, damp will rise through the filling and concrete to the main wall above the damp-course in the latter. The position of the vertical damp-course is marked "V.D." in the sketch. It should be noted, however, that the filling up of the space between the ground and the concrete, even if a vertical damp-course be put in, is not to be recommended. The best way is to lay the concrete on a timber centre,

if the latter can be removed, or, if not, on galvanized iron sheeting. There will then be no filling to cause dampness, and the space under the verandah floor will allow ventilators to be placed in the lower

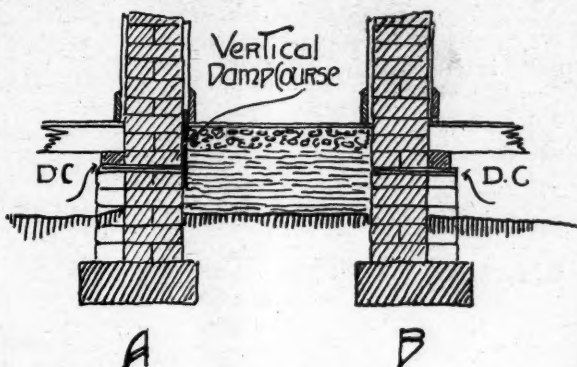


Fig. VI.

part of both verandah and main wall, with a view to the proper ventilation of the space under the floor of rooms on the verandah side of the house. A cause of damp walls which is more often met with than will be expected is shown in the Sketch B (Fig. VI.).

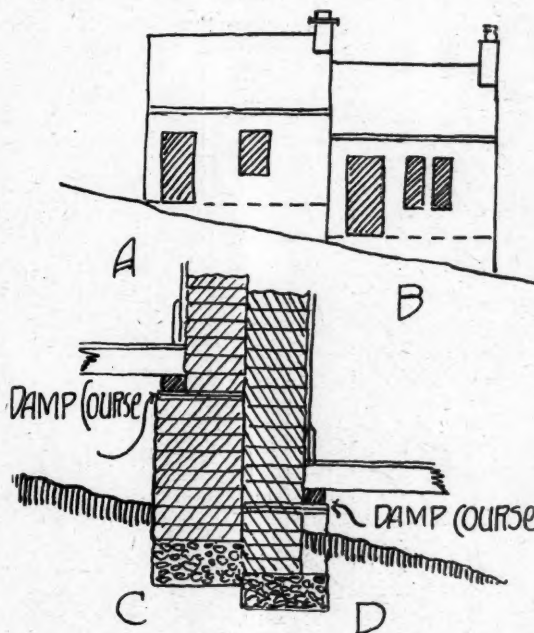


Fig. VII.

It is produced in practically the same way as in the case of the verandah floor filling just described. The sketch represents a section through the lower part of a hall or corridor with a tiled floor. The tiles are supported on a concrete floor, which, in its turn, is supported on a filling of some such material as clay, or even sand. The filling is raised to a level above

the damp-course in the walls, with the result that the moisture rises from the ground through the filling and gets to the walls above the damp-course, and unhealthy conditions are brought about. Either vertical damp-courses should be put in as shown in the sketch, or what will be much better the concrete should be made to support itself, and the space beneath it left quite free.

Figure VII. illustrates a cause of dampness in walls often met with, and which is very easy to avoid, but extremely difficult to remove. The defect is the result of the difference in level between the damp-courses in adjoining walls of houses, one of which houses has been built later than the other. The trouble often arises when houses are built facing a street with a good slope or fall, and when, as a consequence, the ground floors are on different levels.

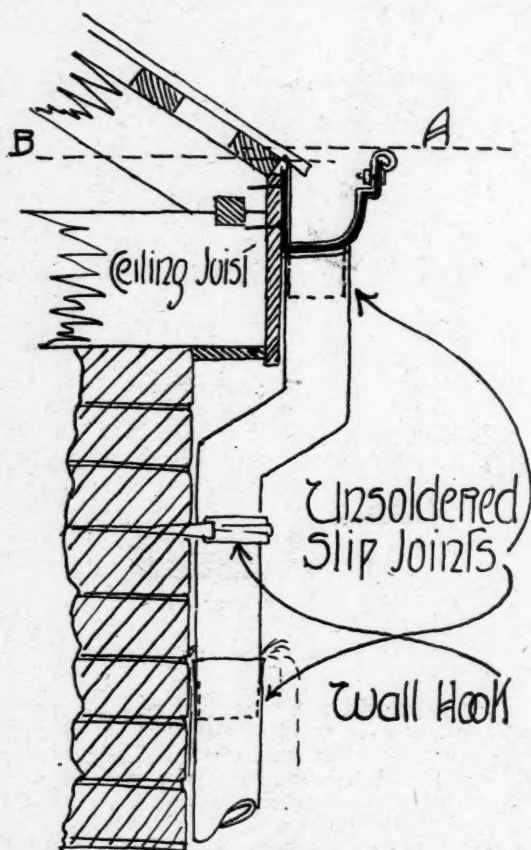


Fig. VIII.

The trouble is particularly liable to be brought about when the house with the higher level of ground floor is built last. The section in the lower part of the sketch shows how the wall of the lower house will be damp. The wall at "C" will absorb the moisture from the ground to the level of its damp-course. The level of the damp-course in this wall is higher than that of the damp-course in the

wall at "D." The consequence will be that the latter will get moisture from the wall "C," and will have dampness ascending to a considerable height above its floor level. The way to avoid trouble is to put the damp-course in "C" at the same level as that in the wall "D." Two small houses have been selected for illustration, but the liability of occurrence of the defect is not by any means restricted to small houses; in fact, it is likely to occur, if care be not taken, in any external or internal walls in which the floors of adjacent rooms or houses are at different levels.

An excellent means of providing for the space beneath the ground floors being dry and sweet is to cover the whole of the ground under the floors with a layer about 2 to 3 inches thick of tarred ashes rammed tight. This will also help to keep white ants away.

Overflowing eaves gutters, due to insufficient size or faulty fixing, and leaking down-pipes, are frequent causes of dampness in the upper parts of walls. Figure IX. shows a bad method of fixing

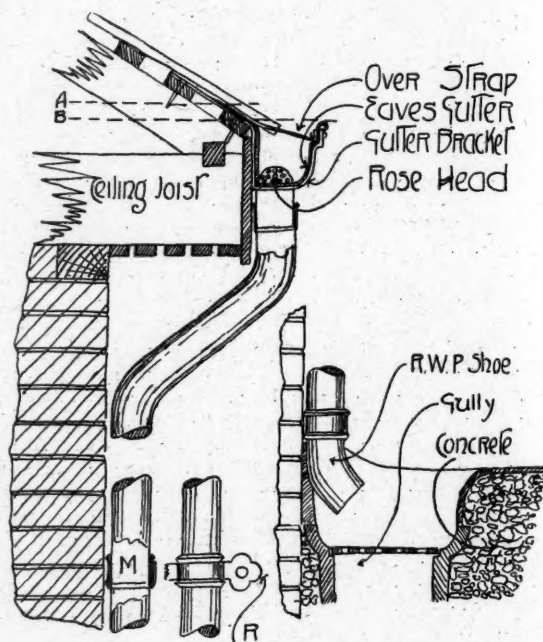


Fig. IX.

eaves gutters and down-pipes. The bracket holding up the eaves gutters has its back no higher than the back of eaves gutter, and is nailed to the fascia board. The nails are easily drawn out by the weight of the gutter, with the result that the gutter leans over or becomes quite loose, and during rain overflows and saturates the walls. Figure IX. shows the proper kind of gutter bracket. It will be seen that the back of the bracket extends up over the roof battens, and is nailed to them. The driving of the

nails is at right angles to the length of the upper part of the gutter bracket, and the weight of the gutter is not at all effective in drawing them. An over-strap from the front edge of the gutter, and extending up to and over the battens, tends to keep the front edge of the gutter from leaning outwards, and is a further preventive of overflowing.

Figure VIII. also shows a badly-designed and badly-fixed down-pipe. The bends are sharp, and the joints are merely made by slipping each piece of the pipe into the piece below it. The consequences are that, owing to the sharp bends, the pipe does not carry away the water quickly enough, and the gutter overflows. Further, the leaks which occur at the slip-joints are prolific causes of dampness in the parts of the walls behind the joints. The wall hooks shown in the sketch, driven, as they usually are, merely into the joints of the brickwork, soon become loose, and are useless as fastenings. Figure IX. shows the way the bends should be formed, and the proper method of making the joints. It will be seen that the joints are formed in the same way as are the joints in cast-iron pipes for water supply, and caulked with some kind of water-proof caulking. Ordinary white lead paint and hemp make a good caulking. The down-pipes should be fixed to the walls with stout straps, as shown at "R" in the sketch. The screws holding the straps should be screwed into cedar plugs driven into the brickwork. A rose head should be put in the bottom of the gutter over the opening to the down-pipe. This will prevent leaves and other refuse from getting into and stopping the down-pipe. Down-pipes should never be connected directly to the drains. If they be connected there is danger of them acting as vents to the drains and distributing foul air at the level of the eaves, and, consequently, perilously near to the window levels. The lower sketch shows the proper way to arrange the passage of water from the down-pipe to the drain. The down-pipe has a shoe, which empties over a gully, which, in its turn, forms a trap to the drain. Particular care should be taken to make the surroundings of the gully water-tight. If this precaution be neglected, the water, in splashing about the top, will soak into the ground and disturb the foundations. None of these details described as being necessary for the efficient carrying off of the rainwater from the roofs to the drains are very costly, and all are well worth the most careful attention.

Some references have already been made in these notes to the necessity for avoiding, as far as possible, all covered up crevices in the walls and other parts of the construction of the house. It is impossible within the limit of this paper to describe all the places where these covered spaces for the accumulation of dust and filth can occur. A good example of one case can, however, be given. Sketch C (Fig. X.) is a section through a skirting board. It will be seen that the plaster is carried down for only a little way below the top of the skirting board, thus leaving a space, which becomes gradually filled with dust, and often enough is the harbour of mice. The

plaster should always be carried right down to the floor, and the skirting put close up against it. The other sketches in Figure IX. illustrate various parts of the exposed internal portions of the house, where dust and even worse can accumulate. The top left-hand sketch "A" is a badly-designed ceiling cornice, the curves of the moulding of which are so shaped as to afford easy catchment for dust. Sketches B and E are sections of mouldings such as are put round doors and windows and are used for picture-rails. All these kinds of mouldings are liable to catch dust, and are very difficult to clean. The Sketch G shows section of a plain moulding, which will not hold the dust. The house builder should realize that a simple band, well-finished as regards colour of stain or paint, looks quite well in its simplicity and cleanliness, when compared with a much-curved moulding, with its recesses full of not easily removable dust.

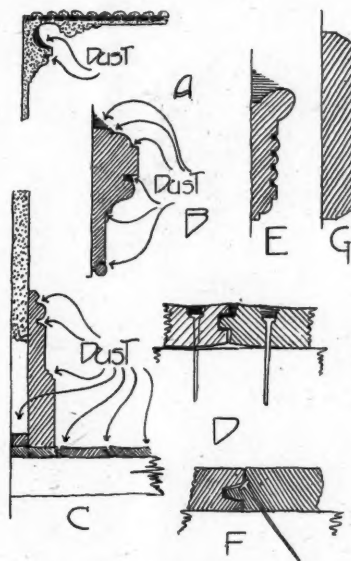


Fig. X.

There is no part of a house that gets, as a rule, so little attention as the floor boarding, and yet this point is anything but unimportant. The usual kind of boarding, from four to six inches wide, is generally quite green when laid, and shrinks to such an extent that the longitudinal joints become in a very short time gaping crevices. These crevices, together with the nail holes, made larger by the punching, are receptacles for filth to an extent that would appal the ordinary dweller in the house could he be made to understand. The Sketch D (Fig. X.) shows a section through a joint of the ordinary house flooring boards. It is quite an important matter that only very well seasoned timber should be used for the flooring boards, and if at all possible the fastening to the joints should be by means of secret nailing. Sketch F (Fig. X.) shows how this is done. One board at a time is laid, and the

nails are driven only on the edge with the "tongue" and in just above the top of the latter. This method prevents any of the nail-holes being open and visible. It is always worth while to have the upper surface of the floor planed off smooth after laying. The floor can then be kept perfectly white by scrubbing in the kitchen, or can be stained and polished for other parts of the house. No doubt such floors mean more work than the ordinary kind of floor, with its filth-holding crevices covered up with linoleum or carpets, but the gain in healthy conditions and appearance is worth the extra labour involved. The point in this connexion that should be recognized is this: plan the internal decoration of walls, ceilings, doors and windows on simple and plain lines. The labour saved in keeping these parts clean can be expended in keeping exposed floors either scrubbed or polished. Such a house, while being clean and healthy, need not necessarily be ugly; indeed, on the contrary, it can be very beautiful.

PROLAPSE OF THE FEMALE BLADDER.

By Arthur J. Nyulasy, M.R.C.S. (Eng.),
Gynaecologist to the Perth Hospital.

A complete understanding of the causation of pronounced prolapse of the female bladder is compatible only with an accurate knowledge of the anatomy of the cardinal ligaments. Without such knowledge the evolution of the ideal surgical treatment of the prolapse becomes impossible. These ligaments are the main element holding the uterus at a more or less definite level in the pelvis. Springing on each side from the lateral wall of the uterus and from the lateral vaginal fornix the heads of origin converge to form a fibro-muscular band about half an inch broad passing outwards for about an inch, the ligament being adherent to the posterior layer of the broad ligament, and having the bladder resting on its anterior surface. The transverse part of the uterine artery courses inwards on the anterior surface of the body of the cardinal ligament, the upper free margin of the ligament slopes downwards and outwards, while the lower margin is in relation with the transverse vaginal vessels by connective tissue. Out near the origin of the uterine artery this surgical segment of the cardinal ligament spreads out fanwise into fibrous bands inserted mainly into the pelvic fascia. Towards the outer end of the inner surgical segment of the ligament a strong fibro-muscular band is given off and inserted into the postero-lateral wall of the bladder in a position corresponding generally to the ureter. This bladder attachment explains how in overstretching of the cardinal ligaments (with coincident or consequent lengthening of the utero-sacra) we not only get prolapse of the uterus, but also dropping of the bladder. On account, too, of the important bladder attachments of the cardinal ligaments my operation of curtailing the ligaments by stitching a loop in each to the front of the uterus (looping the cardinal ligaments)¹ not only raises the prolapsed uterus to

its normal level, but also largely removes the accompanying cystocele, the removal of the cystocele being still more ensured by curtailing the utero-sacral ligaments, the tensors of the anterior vaginal wall.

In a small percentage of cases in which vaginal hysterectomy is carried out for the cure of *prolapsed uterus*, the bladder later on prolapses to such an extent that a large portion of the viscus is found external to the vagina. To prevent this effect after vaginal hysterectomy for *prolapsed uterus* Charles Mayo² stitches the stumps of the broad ligaments together in the mid-line, as well as to the surrounding parts below the bladder, thereby forming a floor, on which the bladder rests. Now, since the main structures of any breadth and strength in the broad ligament stumps are the cardinal ligaments, the breadth of origin from uterus and vagina being especially marked, it follows that the net result of Mayo's operation is that the bladder, instead of being held up or suspended by the cardinal ligaments, rests upon them as on a platform. In this regard Mayo appears to overlook anatomical facts established by my investigations of the cardinal ligaments. He thinks highly of his operation from the standpoint of clinical results, and illustrates it by very fine drawings. However, it is my experience that if in vaginal hysterectomy for *prolapsed uterus* the over-stretched cardinals are adequately shortened and the stumps stitched either to the lateral angles of the vagina or to one another in the mid-line, the bladder will be unlikely to prolapse seriously, or, at any rate, to any greater extent than can be relieved by the classical operation for the slighter grades of cystocele.

When a very high degree of bladder prolapse follows vaginal hysterectomy for *prolapsed uterus* we have a difficult problem to solve. The plight of the patient is a most deplorable one, and she is probably quite ready to submit to any operation the surgeon may consider likely to afford relief. A case of this kind was recently under my care in the Perth Hospital, the patient being a somewhat stout, flabby multipara of 70 years of age, with a decidedly rickety heart, while the vessels showed marked senile changes. Fifteen years earlier vaginal hysterectomy had been performed in another State for prolapse of the uterus. Soon after this operation the bladder "came outside," and when I saw the case practically the whole viscus appeared to be external to the vagina. Various procedures suggested themselves to my mind, the ideal operation being to open the abdomen, seek the retracted ends of the cardinal ligaments, and stitch them together in the mid-line. So, too, I thought, as an alternative, of opening up the peritoneum between the bladder and rectum, and stitching the bladder high up to the front of the rectum, and perhaps also to the sacrum. However, the case was a poor surgical risk for abdominal section, and it was impossible to forecast what technical difficulties might be encountered. The ideal operation or any other by the abdominal route being regarded as out of the question, it was decided to attack the bladder from below. As the patient had a fairly large incomplete laceration of the perineum, I first carried out my T-operation to relieve this

condition. In this operation a vaginal flap is raised to expose the diastased *levator ani*, these muscles, with their fascia, are sutured together, and the free margin of the flap sewn down to the terminal half inch of raw skin edge on each side, the total suture-line taking the form of a T. No tissue is removed, and the operation secures as close a restoration of the parts to the normal as can be expected from surgery. In the present case the operation proved difficult, on account of senile changes, and because of the long period which had elapsed since the perineum had been torn, the stitches bringing the levators together being under no little tension. By strict cleanliness, and keeping the parts dry by an antiseptic dusting powder, a practically perfect result was achieved. A small vaginal introitus still remained, and through this the bladder prolapsed in the erect position. How was this opening to be satisfactorily blocked? A small Zwancke pessary, with its leaves resting on the approximated levators, proved completely efficient, the patient having her bladder retained in the pelvis for the first time in fifteen years.

References.

¹ Arthur J. Nyulasy, "Looping the Cardinal Ligaments in Uterine Prolapse," *Annals of Surgery*, April, 1914; *ibid.*, "Observations on Uterine Displacements," *Surgery, Gynecology and Obstetrics*, January, 1916; *ibid.*, "The Cardinal Ligaments: Their Genesis," *The Medical Journal of Australia*, August 26, 1916.

² Charles H. Mayo, "Uterine Prolapse with Associated Pelvic Relaxation," *Mayo Clinics*, 1914.

Medical Matters in Parliament.

VICTORIA.

(Continued from page 253.)

The Hon. W. J. Beckett moved that the following new sub-clause be added to the clause—

(4) Every medical practitioner in receipt of any salary or fee from the Government shall examine and treat free of charge to such person any person suffering from venereal disease who applies to him for examination and treatment, and the Minister shall pay a reasonable remuneration for such examination and treatment.

Any medical practitioner who neglects or refuses to examine or treat any person as provided by this sub-section shall be liable to a penalty of not more than £5.

After discussion, in which it appeared to be preferable to insert the new sub-clause in clause 19, the amendment was withdrawn.

The clause as amended was adopted.

Clause 11 was adopted after the Hon. J. D. Brown had suggested an amendment dealing with unscrupulous medical men who gave certificates.

Clause 12 was agreed to.

On clause 13, giving power to order persons suspected of suffering from venereal disease and not under treatment to submit to treatment, the Hon. J. D. Brown moved in sub-clause 1, reading—

Whenever the medical inspector is satisfied by the certificate of a medical practitioner or by statutory declaration that any person is suffering from venereal disease, and is not under treatment by any medical

practitioner, he may issue an order in writing requiring such person to place himself forthwith under the care of a medical practitioner.

that the words "or by statutory declaration" be struck out. After a long discussion the amendment was negatived.

The Hon. W. S. Manifold moved that after the words "declaration that" the words "there is reasonable ground to believe that" be inserted.

The amendment was agreed to.

The Hon. J. D. Brown moved, in sub-clause 2, reading—

(2) If such person does not place himself under the care of a medical practitioner a police magistrate on the complaint of the medical inspector or of a medical practitioner authorized in writing either generally or in any particular case for the purpose by the medical inspector may by warrant under his hand in the prescribed form and directed to prescribed persons order the person to be apprehended and to be detained for any prescribed period not exceeding four weeks in any prescribed place for any clinical chemical bacteriological or other examination or investigation necessary to ascertain whether such person is suffering from venereal disease, and it shall be lawful to make any such examination or investigation; and such warrant shall be a sufficient authority to all persons for the arrest and detention of such person in pursuance of the warrant and subject to the provisions of this Part of this Act.

that after the word "complaint" the words "on oath" be inserted.

The amendment was withdrawn.

The Hon. W. J. Beckett moved that the words "such order to be registered letter" be inserted in sub-clause (1) after the words "order in writing."

The amendment was negatived.

The Hon. J. D. Brown now moved the amendment which he had withdrawn to allow Mr. Beckett to move his amendment. After debate the amendment was negatived.

The Hon. J. D. Brown moved that the words "medical inspector" in sub-clause (2) be struck out with a view to inserting "a police magistrate."

The amendment was negatived after a long discussion.

The Hon. J. D. Brown moved, in sub-clause (3), reading—

(3) If the result of any such examination or investigation discloses that such person is suffering from any venereal disease, and the medical inspector, after due inquiry into all the circumstances, is of the opinion that further detention is necessary in the interests of such person and of the public welfare, and so reports to the Minister, then, on the recommendation of the Minister the Governor-in-Council from time to time may order that such person shall be detained under such conditions and in a prescribed or proclaimed place and for such time and be subject to such examination and treatment as are necessary to insure that such person is cured or is free from venereal disease, or has ceased to be liable to convey infection; and the Governor-in-Council may extend or vary any such Order or at any time terminate its operation, and thereafter, if found necessary, renew such Order. And every such Order shall be sufficient authority to all persons for the arrest and removal or detention of such person in pursuance of the Order until his release under the provisions of this section and subject to the provisions of this Part of this Act.

that after the words "public welfare" the words "and so reports to the Minister, then on the recommendation of the Minister, the Governor-in-Council may from time to time" be omitted, and before the words "may order" the word "he" be inserted.

The amendment was negatived.

The Hon. J. D. Brown moved, in sub-clause (4), providing, *inter alia*—

Any person undergoing detention under this section may from time to time apply, in writing, in the prescribed form, to a Judge of the Supreme Court, or Judge of County Court, or police magistrate to be examined by two medical practitioners, and thereupon such Judge or magistrate shall by order direct any two or more medical practitioners named in the order (one

of whom shall be nominated by the patient or some person on his behalf), to examine such person accordingly, and report the result of the examination to the Judge or magistrate, and every officer or person in whose custody the person is shall permit the examination.

that the words "or police magistrate" be omitted.

The amendment was negatived.

The Hon. J. D. Brown moved that the words "or more" be inserted before "of whom" in sub-clause (4).

The amendment was negatived.

Progress was reported.

The House went into Committee for the further consideration of the Bill upon December 6, 1916.

The Hon. A. Robinson moved, in sub-clause (4), reading—

If it appears from such report that all such medical practitioners are of opinion that the person is cured, or is free from venereal disease, or has ceased to be liable to convey infection, the Judge or magistrate shall order the release of such person from detention, and he shall be released accordingly.

that the words "if it appears from such report that all such medical practitioners are" be omitted with the view to inserting the words "if, after consideration of such report, the Judge or police magistrate is."

The amendment was agreed to. The clause as amended was adopted.

Clauses 14 and 15 were agreed to.

Clauses 16, 17 and 18 were agreed to.

Clause 19, dealing with the duty of hospitals to provide treatment, was agreed to after some discussion.

On clause 20, reading—

The Minister may say—

- (a) establish hospitals or places for the reception and treatment of persons suffering from venereal disease;
- (b) arrange for the examination or treatment by medical practitioners of persons suffering from venereal disease and for the remuneration of such practitioners under any such arrangement;
- (c) arrange for clinical, chemical, bacteriological, and other examinations and investigations free of charge, for the purpose of ascertaining whether a person is suffering from or is cured of any venereal disease, or whether he has ceased to be liable to convey infection;
- (d) arrange for the supply of drugs, medicines, and appliances for the treatment, alleviation, and cure of venereal diseases in the cases of persons unable, through poverty or otherwise, to pay for such drugs, medicines, or appliances; and
- (e) provide for the preparation and distribution of information relating to venereal diseases.

The Hon. J. D. Brown moved that paragraph (a) be struck out.

The amendment was negatived.

The Hon. A. Robinson moved that the word "clinical," in paragraph (c), be omitted, that the words "to the patient" be inserted after the word "charge" in line 3, and that the words "and for the remuneration payable under any such arrangement" be added to the same paragraph.

The three amendments were agreed to. The clause as amended was agreed to.

On clause 22, giving the power to make regulations, the Hon. J. D. Brown moved to omit paragraph (g) providing for the remuneration of medical practitioners and the insertion of a new paragraph, reading—

- (g) Prescribing the periods during which, according to the stages or phases of the disease persons suffering from any venereal disease are to attend or cause themselves to be attended by medical practitioners for the purpose of treatment and advice.

The amendment was agreed to.

The Hon. A. Robinson moved that paragraph (h) be omitted, and that a new paragraph be inserted—

- (h) The fees payable to medical practitioners for notices given to the medical inspector pursuant to this part of this Act.

The amendment was agreed to.

The clause as amended was agreed to, and also clause 23. On clause 24 the Hon. H. F. Richardson moved to amend the section to read, "Any person who exhibits in any pic-

ture, theatre or place of public resort any film or cinematograph, or any person."

The amendment was agreed to after discussion.

The Bill was reported with amendments.

Clause 6 was recommitted on the motion of the Hon. A. Robinson.

The Hon. A. Robinson moved that a patient "furnish his correct name and address to such medical practitioner."

The amendment was agreed to. The clause was adopted.

The Bill was reported with a further amendment.

The Hon. A. Robinson moved that the Bill be read a third time.

The motion was agreed to, and the Bill was read a third time and passed.

In the Legislative Assembly on December 7, 1916, the Bill was received, with a message intimating that the Council had agreed to the same with amendments, with which they desired concurrence.

The amendments made by the Legislative Council were taken into consideration upon December 1, 1916.

Mr. McLeod, Minister of Health, said that the list of amendments, made in the Council, was a formidable one. Most of the amendments, however, had been inserted to render the clauses more precise. As a matter of fact only one amendment was of importance to the Bill. That amendment dealt with the changes in the Health Act. He proposed to replace the amendment of the Council by a new amendment which would be more comprehensive than that proposed. The new clause would enable the Government to deal with recognized prostitutes who occupied rooms in certain houses, and who contaminated many men. The Minister then explained in detail the amendments proposed by the Council. He moved that the amendment in regard to the retention of clause 206 of the Health Act be disagreed with, but that the following new clause be inserted in the Bill:—

aa. Any person being the owner or occupier of any house, room, or place in which a female suffering from venereal disease resides for the purpose of prostitution, or to which she resorts for such purpose, shall, unless he can prove that he did not know that such female prostituted herself while in a state of disease, be guilty of an offence under this Act, and shall be liable to a penalty of not more than £20, or, at the discretion of the Court, to imprisonment with or without hard labour for a term of not more than six months. Provided that no conviction under this section shall exempt the offender from any penal or other consequences to which he or she may be liable for keeping or being concerned in keeping a bawdy-house, a disorderly-house, or for the nuisance thereby occasioned.

After discussion the amendment was agreed to.

The Minister said that he would move that the remaining amendments be agreed to, unless any honourable member wished to discuss a particular amendment.

Mr. Blackburn wished to refer to the first amendment of clause 24.

The amendment read—

Clause 24, line 17, after "Act" insert:—"there shall be inserted after the words 'Any person' where they first occur the following words—'who exhibits in any picture theatre or place of public resort any film or cinematograph display, and any person,' and,"

He moved that the amendment be amended by the insertion after the word "display" of the words "which is of an indecent or obscene nature." The amendment made by the Council, provided for the inclusion of any film or cinematograph display, but did not make the qualification that it must be of an obscene or indecent nature.

The amendment was agreed to, and the Council's amendment as amended was adopted.

The remaining amendments were agreed with.

The Bill was ordered to be returned to the Legislative Council with a message intimating the decision of the House.

The Legislative Council considered the message from the Assembly upon December 19, 1916.

The amendments were agreed to.

The Bill was returned to the Assembly the same day.

The Royal Assent was given upon December 28, 1916.¹

¹ The text of the Act will be published in next week's Journal.

The Medical Journal of Australia.

SATURDAY, MARCH 31, 1917.

The Extent of the Sacrifice.

During the early days of the war, the members of the medical profession in Australia promised to respect the interests of those practitioners who undertook to serve the Empire. Two general duties devolved upon those who remained at work in their practices in Australia. The first was that the patients of practitioners who had gone to the war would be attended on the understanding that they would be handed back on the practitioner's return. The other was that when a man left his practice in the hands of one or more colleagues, they would look after his patients to the best of their ability and hand to his representatives one half of the fees received from these patients. From a discussion which has taken place recently at a meeting of the Queensland Branch of the British Medical Association, we learn that the men on active service have grave doubts concerning the manner in which their interests are being safeguarded by those at home. Complaints have been made from time to time that some, perhaps many practitioners, are grasping the occasion to make capital out of the patriotic sacrifices of their colleagues. A correspondent writes in the present issue, describing a specific instance of this breach of faith. The facts must be recognized and if possible remedies must be found.

There are two obligations imposed on the profession both of which are associated with the endeavour to limit as far as it lies in the power of those remaining at home the sacrifice these men are making. The man who accepts a commission in the Army Medical Corps, Australian Imperial Force, is prepared to relinquish his home comforts, to undergo any hardships, to expose himself to infections and to work under conditions which must affect his health, and may lead to invalidity or death. Should he be sent to a position within the danger zone he is

exposed to the same risks to life and limb as the combatant soldier. The roll of honour of the medical profession is eloquent testimony to the risks which our brave colleagues have voluntarily incurred. These are matters that cannot be altered. There are, however, smaller sacrifices which can be diminished to a vanishing point, provided that the profession is prepared to do its duty to these men. In the case of many of the younger doctors who have gone out, the loss of income is a serious matter, especially if the doctor is married and has had but little time to put aside money for the proverbial rainy day. The two obligations to which we have referred are that of seeing that no medical man who is serving the country suffers from loss of income during his period of service, and the second that when he returns to Australia his future prosperity must be guaranteed. Dr. Hone has dealt in a most practical manner with the second obligation. We propose to leave this subject for the present. The former obligation has been recognized since the beginning, but, as we have pointed out, it has been flouted on far too many occasions. To find a method by which the man at the front shall not lose and the man at home shall not gain has baffled "Senior G. P." It would seem that the voluntary undertaking cannot be relied upon, and yet we cannot believe that an honourable recognition of a sacred duty will be ignored, if means be devised for approaching the men concerned. Provided that the Medical War Committees can be revived, as suggested in the proposals of the New South Wales Branch in connexion with a compulsory enrolment in the Reserve, local sub-committees might be entrusted with the task of applying directly to every member in the various districts throughout the Commonwealth to furnish them with a declaration of the number of patients of absent practitioners who have been under treatment and the amounts collected from each. The man who stays at home should be asked to hand over to the legal representatives of the absent practitioner half the sum paid as fees by patients of the latter. An alternative proposal has been made to us, namely, that doctors who are conducting good practices in Australia should be asked to pay into a common fund an annual sum of, say, £200 or £300, to cover part of the financial

losses of the absent practitioner. It is obvious that the men in good financial circumstances would not need or desire to avail themselves of assistance of this kind, but inasmuch as it would be handed over not as a gift or compensation, but as a meagre payment of a much larger debt, it should be offered to all those who are absent on active service. A third suggestion would be to ask every practitioner to make a return of his income from practice during the years from 1913 up to the present. Any increase in 1917 in excess of the natural increment of income should be ascribed to fees from the patients of his absent colleagues, and he should be asked to share this sum with them. It is unlikely that any would refuse. In support of the third suggestion it may be pointed out that in industrial circles, the authorities take good care to secure for the public use all surplus war profits. Whichever method might be selected, it would probably be advisable to form a pool or common fund into which all sums could be paid, and from which all disbursements could be made as soon as the wishes of the absent practitioners could be ascertained.

THE PROBLEM OF THE INFANT.

Every health authority throughout the civilized world has considered the problem of reducing its infantile mortality. Countless proposals have been put forward as infallible remedies for the annual loss to the nation. With but few exceptions, to which reference will be made, no definite plan of campaign has been adopted in any European country or in any State of Australia aiming at the removal of the causes of a high death-rate of infants. And yet an extraordinary reduction has been recorded during the course of the past fifty years. There is no difficulty in tracing the reason for this fall in the mortality of infants during the first year of life. Babies die because their resistance to infective and other pathological processes is readily reduced by unnatural modes of being nurtured and housed. Improvement in the hygiene of the home, the removal of overcrowding, the recognition of the baneful influence of dirt and insanitary environ-

ment has contributed to the reduction in the mortality. The Statistical Department of the Government of the Canton of Basel published in the year 1911 a record of the component parts contributing to the infantile mortality. In this publication it was set forth that the infantile mortality had sunk from over 200 per 1,000 births in 1870 to just over 70 in 1910. Westergaard came to the conclusion early in the present century that 70 per 1,000 births was approximately the lowest practical figure to which the mortality of infants under existing conditions could be reduced. This opinion was based on the mortality rates among the rich. The infantile mortality in the Commonwealth, according to the latest returns now stands at 71.5 per 1,000 births. Thus it may be said that a general improvement in the hygienic environment of the infant has reduced the rate by two-thirds. It now becomes necessary to attack the problem from the other point of view, namely, from that of improving the mode of nurturing the infant. Sir Charles MacKellar, M.L.C., has recently addressed an open letter to the Honourable J. D. Fitzgerald, the Minister of Public Health of New South Wales, under the heading: "The Mother, the Baby and the State." In this excellent discourse on the causes of avoidable deaths of infants during the first year of life, he deals out a lesson which everyone acquainted with the problem must endorse. It is to the effect that no greater danger to the baby exists than that lurking in the bottle. He quotes Dr. Eric Pritchard, who summarized the situation in the trite sentence: Infants will live and thrive in spite of poverty and bad sanitation, but they will not survive bad mother-craft. It is now a matter of history that the pioneers in the true campaign against the wastage of infant life in France recognized that the greater part of the trouble could be avoided if mothers could be induced to nurse their babies. Nowhere in the whole world has this campaign been carried out so thoroughly as in Paris. It has been proved that nearly every woman can nurse her infant, and that under given conditions nearly every woman can nurse her baby to its immeasurable advantage. The pleas that the mother has not enough milk, that the milk does not agree with the baby, and so forth, merely denote that there is something interfering with the mother's

natural function. That something can be removed in an overwhelming proportion of cases. If it is caused by worry, some subtle influences may be necessary before the secretion becomes normal; if it is due to some local or general pathological condition, it reveals a neglect of the woman before the infant was born. Sir Charles Mackellar offers the same remedy that has been applied in Paris, and to some extent in other countries. He proposed to supply for the pregnant woman who cannot afford it a rest home, where she can be taken care of during the period preceding the confinement. Antenatal care must be conducted by those who have knowledge and training in this special branch of medicine, and should not be left to an unskilled, half-trained nurse. Sir Charles proposes that the woman should be sent to a maternity hospital at the first signs of labour, and that after the puerperal period has been spent in hospital, she should be discharged to a rest home for a short time, where she could be cared for until she is safe to undertake the supreme task of keeping a human being alive and well. The cost of this scheme should be met out of the money now wasted in the Maternity Bonus, supplemented to a slight extent out of public funds. The success of a proposal of this kind must depend on the extent to which it is applied. One essential is that the machinery shall be effective, and to ensure this, it is primarily necessary that the control of the women's health and the guidance of their management of their infants should be in really competent hands. Regarded in a practical light, the problem of a high infantile mortality is one of pounds, shillings and pence, and the education of women in good mothercraft.

THE MEDICAL PROFESSION IN RUSSIA.

The Russian revolution has come and has apparently succeeded. Up to the present we have but meagre information, and from this no one can prophesy whether the people have finally and permanently emancipated themselves from the autocratic repression and unjust persecution of officialdom. We can but hope that a return to the old order of things has been rendered impossible by recent events. The seeds of revolt were sown years ago; the harvest will be gathered in the future. Perhaps in the

immediate future. At present the effect of the revolution affects us because the conduct of Russia's participation in the war must be profoundly influenced by it. We should not be blind to one fact—that the great mass of the peasantry, the people who have been kept permanently hungry, and subjected to the iron will of the cowardly bully, have up to the outbreak of this revolution not had an opportunity of discovering why the world is aflame, and what Russia is fighting alongside the British and her other allies. The plebs may sympathize with the cause of justice; may desire to help in the overthrow of Prussian militarism. Who knows? They may be incapable of any feeling other than the desire to be free and to live. All this is wrapped in a shroud of impenetrable obscurity, and those enlightened leaders who have full knowledge of the powers acquired by the victory of the people will certainly use this knowledge as wisely as they can, in order to induce the peasants to do their bidding and submit themselves to the great military task. The revolution has succeeded because the people were armed. In the past it failed because only the soldiers of the autocrats had weapons. Since weapons of war have enabled the people to command their freedom, they may be persuaded to use these same weapons for the honour of the name of Russia.

While everyone is equally aware of the political aspect of the present upheaval in Russia, and of the political history of previous attempts to gain the overhand of bureaucracy, the part played by the medical profession in the latter history of the Russian Revolution is not so well known. It has been recorded that increased powers have been granted to the *Semstvos*, and that in those districts where no machinery for local government exists, provisional means are being devised, pending the institution of permanent measures. The medical profession in Russia has attempted to organize itself for political as well as professional purposes, despite the illegality of this procedure. Its members have taken part—a prominent part in the events of the past ten or fifteen years. In order to understand how the medical profession stands to-day, on the accomplishment of its ideal, it is necessary to follow certain events in its history and to compare the official descriptions of the machinery for the preservation of the public health with the accounts given by individual practitioners of the working of the various organizations. This must entail a short sketch of the institution of the *Semstvos* in 1864, with an account of its powers in connexion with hospitals, medical institutions and public health, up to 1890, when their constitution was modified by a pretended removal of bureaucratic control, and their subsequent development. In addition some facts concerning the formation of certain medical associations, and the active participation of societies of medical practitioners in the revolution of 1905-1906, together with some extracts from the published accounts of the conflict between the autocracy and the medical profession are necessary for a better understanding of the position to-day of our colleagues in Russia. These subjects will be dealt with in subsequent issues.

Abstracts from Current Medical Literature.

THERAPEUTICS.

(98) Use of Anti-meningococcal Serum.

C. Gray (*Medical Press*, January 10, 1917) gives an account of 46 cases of cerebro-spinal fever treated with anti-meningococcal sera. Of the forty-six patients ten died, representing a case mortality of 21.7%. Three cases were treated with Mulford's serum and two patients died. Forty-three cases were treated with sera from the Lister Institute. Eight patients died, corresponding to a mortality of 18.6%. Thirty-three cases were treated with serum from the Lister Institute on or before the third day of the illness. Three patients died, representing a mortality of 9.1%. Ten cases were treated with serum from the Lister Institute after the third day of the disease. Five patients died, corresponding to a mortality of 50%. The patients comprised all those admitted to a military hospital in London from December, 1915, to July, 1916, except those brought in moribund. The average duration of the illness in these 46 cases was 19 days. The average figure is, however, misleading. Several patients who were severely ill, were convalescent in six days. With a few exceptions all the patients were convalescent in 14 days. One patient was ill for over three months. All the patients received good nursing, ample nourishment and symptomatic therapeutic treatment. The anti-serum was given under a general anæsthetic. The skin was prepared with care. The lumbar puncture was made in the middle line. The spinal fluid was allowed to escape until the flow diminished to a rate of one drop in two or three seconds. When the spinal fluid was turbid, the intrathecal space was washed out with normal saline solution. Thirty cubic centimetres of the saline solution were passed through a funnel into the intrathecal cavity after the excess of spinal fluid had run away. By depressing the funnel the solution again ran out from the sub-arachnoid space. Thirty cubic centimetres of the anti-serum were given by the funnel into the intrathecal space. The serum was given upon three successive days, however well the patient seemed. In severe cases, after seven or eight doses of serum, lumbar puncture alone was employed. The most frequently observed effect of the administration of serum was a diminution in the degree of fever. After two or three injections the number of meningococci in the spinal fluid was lessened. Headache and delirium disappeared, the rigidity of the neck diminished, and the appetite returned. The diagnosis in these 46 cases was based upon bacteriological examina-

tions. A positive diagnosis was made when the meningococcus was grown from the cerebro-spinal fluid, or when Gram-negative cocci were seen in the cerebro-spinal fluid and a growth of meningococci obtained from the nasopharynx. The author advises that two swabs should be made from the nasopharynx for diagnostic purposes in every suspected case of cerebro-spinal fever. As an example of the influence of the intrathecal injection of serum the following history is related. A soldier was taken suddenly ill during the night. The next day he was removed to hospital. On admission he was vomiting, noisily delirious and passing urine and feces involuntarily. There was rigidity of the neck, retraction of the head and lateral decubitus. The temperature was 103.8° F., and the pulse rate 64. He received 30 c.cm. serum upon three successive days. On the second day the temperature was 100° F., and the next night 99° F. On the morning of the fourth day he was rational. By the fifth day he asked for solid food. By the end of a week he was up.

(99) Does an Iodide Enter the Spinal Fluid.

J. S. Catton (*Journ. Amer. Med. Association*, November 4, 1916) has made a series of examinations of the cerebro-spinal fluids of persons receiving treatment with potassium and sodium iodides. He removed the spinal fluid by lumbar puncture from five patients receiving routine medication with potassium iodide. Two punctures were made. At the first tapping as much fluid as possible was taken away. The second tapping was made a varying time after the first. This time has been 24 hours, 48 hours, 51 hours, 76 hours, and 10 days. One patient had been taking iodides for one month, another for 11 weeks, and the others for three months. The whole of the fluid obtained at each tapping has been used for a delicate qualitative test for iodine. None has been detected in any of the ten specimens. Two of the patients were suffering from tabes, one from cerebral syphilis, while the cerebral lesion was not determined accurately in the other two cases. Some observations have been made on another case of tabes. The patient was commencing treatment. He received during six days gradually increasing doses of potassium iodide, starting with 15 grains, and ending with 40 grains. On the seventh day he took *per os* 250 grains in a single dose. Fluid was withdrawn by lumbar puncture 18 minutes later. Another sample of cerebro-spinal fluid was taken after 24 hours. A week later 240 grains of sodium iodide were given by the mouth, and cerebro-spinal fluid was taken in 30 minutes. Portions of the last two fluids were given to different physiological chemists for examination for iodine. Three separate methods were used, but no iodine could be found in any of the samples. It thus appears that iodides do not reach the cerebro-spinal fluid.

(100) Heliotherapy in Surgical Tuberculosis.

H. J. Gauvain describes the methods used at Alton in the treatment of tuberculous crippled children, and relates his impressions of the results which have been obtained (*British Journ. Tuberculosis*, July, 1916). He is satisfied that extravagant claims for the results of sun treatment cannot be sustained. Sunlight alone will not cure the majority of the more severe forms of tuberculous disease. The author employs natural sunlight as well as artificial light. As a source of artificial light (ultra-violet radiation) he uses mercury vapour lamps in quartz containers. He considers the effect of sunlight different from that of artificial light. Sunlight readily gives rise to pigmentation of the skin. Pigmentation is produced with much difficulty by exposure to lamps. The effect of the lamp may be so powerful as to cause necrosis but it does not induce pigmentation. The author believes that the production of pigmentation is essential to attain the remote benefits of solar radiation. He gives directions for the practical production of pigmentation without blistering of the skin. Superficial lesions heal rapidly on direct exposure to the sun, though tuberculous masses may remain in the depth of the healed tissue. These may break down later. The author is of opinion that the progress of pigmentation is a reliable index of the improvement in the patient's condition.

(101) Digitalis in Pneumonia.

A. E. Cohn and R. A. Jamieson have studied the use of digitalis in patients suffering from pneumonia (*Journ. Exper. Medicine*, January, 1917). The observations were made upon 105 patients ill from pneumonia. Digitalis was given by the mouth as tablets of digipuratum in doses of 0.4 gm. daily to 49 patients. The remaining 56 patients served as controls. Electrocardiograms were taken upon all the patients. The guides accepted for the action of digitalis, were an alteration in the length of the auriculo-ventricular interval and the effect upon the T-wave. In some cases in which auricular fibrillation was present, an effect upon the rate of ventricular contraction has been noted after the administration of digitalis. The changes observed have been ascribed to digitalis, since they appeared invariably after the administration of a certain amount of the drug. Similar changes have been noted in healthy persons after the use of the same quantity of digitalis. From these observations the authors conclude that digitalis acts during the febrile period of pneumonia. They are of opinion that, whatever changes are produced by digitalis in the normally beating healthy heart, are produced by the same amount of the drug in pneumonia. The effects are most beneficial in cases with auricular fibrillation. In these cases the employment of digitalis may save life.

(102) Heliotherapy in Norway.

W. Holmboe gives some interesting facts about heliotherapy from Norway (*British Journ. Tuberculosis*, July, 1916). Despite the fact that the shade temperature is quite low, heliotherapy can be applied freely in Norway if the patient is kept in absolutely still air. The sun temperature is quite high even in February, when it reaches 134° F. Patients lie nude exposed to the sun when the air temperature is only 14° F. The sun is so warm that the sunbath is most enjoyable. The patient lies in an open verandah exposed to the direct rays of the sun. The verandah is so arranged that no movement of the air takes place. In using sun treatment the legs are first exposed, then the thighs, later the abdomen and finally the whole body.

UROLOGY.**(103) Two-stage Prostatectomy.**

P. M. Pilcher describes in considerable detail the technique of the two-stage method of enucleating the prostate (*Surg., Gynec. and Obstet.*, February, 1917). By following this technique first step consists in the accomplishment of renal decompression with the least risk. This is carried out by a preliminary suprapubic cystotomy. The cystotomy must be carried out in such a manner to ensure complete urinary drainage without any leakage around the tube. The cystotomy wound must be induced to heal by first intention. Following this stage, transvesical enucleation of the prostate is carried out without reopening the prevesical or perivesical tissues. The enucleation is not undertaken until the stage of depression has passed; the urgency is passed and there is no hurry to complete the procedure. The operation should be performed with the inhalation of the smallest essential amount of anæsthetic. Hæmorrhage must be controlled as perfectly as possible. Finally, the patient should be kept dry, the period of confinement should be shortened, and the bladder should be re-educated as early as possible. In regard to the first stage, the procedure is performed under local anæsthesia. Pain and shock can be reduced to a minimum. The principal points in the technique consist in the cleaning of the bladder wall with the finger, and pushing back of the peritoneal covering as near the fundus as may be. All dead spaces must be closed, and the opening must be sufficiently far from the urethral opening to secure a satisfactory drainage. The peritoneum is held back by a retractor and the bladder opened between stay sutures. If it be found that the opening is too low, a fresh site should be chosen and the first opening closed. After the knife has penetrated the wall, the finger is inserted into the organ

for the purpose of exploring the interior and removing any foreign bodies of calculi. As the finger is withdrawn a button drainage tube is inserted. This tube is so constructed that its button-shaped expanded end is grasped by the bladder wall, and the opening thus securely sealed. The wound is then closed in stages, so that no leak can take place. The urine is watched during the interval between the first and the second stage, and as an opening is provided no urethral instrumentation is required. The enucleation is performed through the drainage tube opening, enlarged if necessary by lateral and downward incisions. On no account is the old wound opened upwards, because of the risk of wounding the peritoneum. When the approach is difficult, the subcutaneous tissues and even the muscular layers of the abdominal wall may be divided. The enucleation is undertaken from within the prostatic urethra. First of all the sphincter muscle around the prostatic mass is freed. This is important, since the preservation of this muscle ensures a rapid arrest of bleeding. After this part has been separated, the finger gradually works around the prostate, freeing every particle as far as the membranous part of the urethra. If pieces of prostatic tissue are left behind, they must be removed after the mass has been delivered into the bladder. Next the bladder is emptied of the mass and of calculi, if present. The surgeon must make sure that nothing is left. The bleeding is controlled by the author's hæmostatic bag, a sort of modified de Ribes' bag, with a central tube ending in a catheter tube. The tube for inflating the bag passes through the suprapubic drainage tube, while the continuation tube is brought out through the urethra by means of a silver catheter passed from the meatus. The hæmostatic bag and large drainage tube are removed after from 24 to 48 hours, when the button drainage tube is replaced. As soon as healing is progressing the re-education of the bladder is begun. The enucleation should not be attempted without sutures supporting the original cystotomy wound.

(104) Experience in Renal Surgery.

The President of the Royal College of Surgeons of Ireland, W. Taylor, gave a résumé of his experiences of renal surgery before the Section of Surgery in the Royal Academy of Medicine in Ireland (*Dublin Journ. Med. Sciences*, December 1, 1916). He performed 138 operations on 128 patients, including 92 fixations, 26 total nephrectomies, one partial nephrectomy, and 19 nephrotomies. He lost one patient. The patient was operated on for hydronephrosis; the kidney was removed and the patient did well. On the tenth day he was allowed to sit up, and on the thirteenth day he was able to walk about. He decided to walk round his room before going to bed that evening, and was found by the nurse sitting in a chair, dying. The author recites the case of another patient

who had had an attack of pneumonia 12 months before. The attack terminated with the expectoration of a considerable quantity of pus. Following this he had a feverish attack every week or ten days, felt ill, and then had a fit of coughing and expectorated a quantity of pus and blood. There was a swelling extending downwards from the sixth rib to the iliac crest on the right side. The diagnosis of hypophrenic abscess communicating with the lung was made. The urine contained a few pus cells. An exploratory operation revealed the liver to be normal, but the kidney was found to be the seat of an abscess, which communicated with the lung. The abscess was opened and its contents evacuated. Later, after the patient had improved, this organ was removed, in spite of difficulty. The tumour was a typical hypernephroma. Taylor sums up his experiences by stating that when symptoms are unquestionably caused by movable kidney, or when renal changes are being induced by the mobility, nephropexy is preferable to the use of any mechanical apparatus, and is devoid of risk. Once calculi have been diagnosed, they should be removed without delay by operation. The mortality following nephrotomy in aseptic cases is not more than 2%, whereas the mortality of nephrectomy for calculous disease is about 17% or 18%. Tuberculosis of the kidney is best treated by nephrectomy, performed as soon as possible after the diagnosis can be made, and if possible before secondary infections have occurred elsewhere. The prognosis of nephrectomy for hypernephroma if performed before secondary deposits have occurred in other parts is favourable. Partial nephrectomy is an operation of limited usefulness, but is a safe procedure.

(105) Obstructive Prostatic Calculi.

W. W. Townsend described three cases of a condition which he calls calculous prostate causing urinary obstruction, and takes into consideration the records of other cases published elsewhere (*Surg., Gynec. and Obstet.*, December, 1916). Although the condition is a rare one, notes of over 50 cases are available. The condition has been diagnosed only once prior to operation. As a rule, the microscopical appearances of the urinary sediment are no guide to the diagnosis. Hæmaturia occurs occasionally, and in the absence of other definite symptoms may suggest a degenerate condition of the prostate. The author considers that difficulty of catheterization and physical signs of contracture of the neck of the bladder should cause the surgeon to think of this condition. In the cases recorded the prostate on rectal examination was apparently normal, and was not sensitive to palpation. An operation was undertaken as an exploratory measure in each case when the symptoms were not explained by any physical sign. He suggests that radiography might assist in the diagnosis.

British Medical Association News.

SCIENTIFIC.

A clinical meeting of the Victorian Branch was held at the Out-patients' Department of St. Vincent's Hospital, Fitzroy, on March 7, 1917, Professor R. J. A. Berry, the President, in the chair. The procedure followed included the examination of patients selected by the members of the Staff, and of the specimens placed on exhibition. After sufficient time had been given for the members to have visited each Department, they re-assembled for the purpose of discussing the cases.

Dr. D. Murray Morton exhibited a patient to illustrate Murphy's operation of *arthroplasty of the knee joint*. The patient was a woman, 40 years of age, who had suffered from bony ankylosis of the knee joint of 12 months' standing. The ankylosis had followed an acute arthritis of unknown origin. The operation had been carried out in October, 1915. It had resulted in a perfectly serviceable limb. She was able to walk two miles without discomfort. She wore a hinged lateral support for safety.

Dr. Murray Morton also demonstrated a case of spinal caries for which *Albee's bone graft* had been employed. The patient, a male aged 32 years, had been admitted into hospital two years before. Hibb's operation had been performed without benefit. He had been readmitted in October, 1916, and Albee's operation had been carried out. He had gained one stone in weight in two months, and felt better than he had ever done before. The patient wore a spinal support, but Dr. Murray Morton proposed that this should be discarded at a later date.

The third patient shown by Dr. Murray Morton was a male, aged 28 years, in whom an *intramedullary bone transplant with Lane's plating* had been applied for an ununited fracture of the humerus. The operation had been performed five months after the fracture. Repair was progressing, but the union was not quite firm at the time of demonstration.

Dr. Murray Morton also showed a male patient, aged 28 years, in whom he had carried out a two-stage *transplantation of skin with the superficial fascia* from the left thigh to the right foot. A mid-tarsal amputation had been performed one year before. There had been recurrent ulcers on the face of the stump. A well-padded stump had been obtained by the operation.

Mr. H. B. Devine exhibited six patients. The first was a male (J. T.) with a non-united compound fracture of the leg and a discharging sinus. The condition had been present for 12 months. The ends of the bone had been trimmed at an operation by means of a motor-driven saw, and a *bone graft* had been inserted by *Albee's method*. The point of interest in the case was the healing of the bone graft in the presence of a small septic sinus. Union had commenced after from three to four weeks, and the patient had left the Hospital seven weeks after the operation.

The second patient, a married woman (Mrs. B.), had been under treatment for a *myeloid sarcoma of the humerus*. The head and upper part of the diaphysis of the humerus had been removed, and the middle third of the fibula had been transplanted to replace the resected segment. One end had been implanted into the distal part of the humerus and the other had been sutured into the remains of the capsule of the shoulder joint. Primary healing had taken place. The patient at the time of exhibition, i.e., one year nine months after the operation, was quite well. Mr. Devine exhibited a photograph of the patient, a radiogram of the limb, and the resected tumour.

Mr. Devine's third patient (J. F.) was demonstrated as an example of a series of four cases of *malignant disease of the lower bowel* dealt with by operation. Five years had elapsed since the operation in his first case. He had removed the coccyx, had dislocated the anal canal from the sphincter and *levator ani*, and had divided the superior hæmorrhoidal artery by means of special artery forceps. The portion of the sigmoid flexure lying between the first and second sigmoid arteries had then been loosely implanted into the bare *sphincter ani*. This muscle, together with the *levator ani* had then been sutured, and the displaced

segment, which was between 12 and 14 inches in length, had been allowed to hang down wrapped in dressings. The bowel usually sloughed off about an inch from the anus. There had been very little shock as a result of any of the operations. The parietal peritoneum had been sutured completely around the sigmoid flexure so as to leave no bare area. The results were far better than any that he had obtained in malignant disease of the bowel treated by other methods. Mr. Devine pointed out that the sphincter could be felt by the finger to be normal in tone.

The fourth patient was a male aged 47 years, who was suffering from *carcinoma of the body of the stomach*. Mr. Devine had removed the greater part of the organ. A small portion of the cardiac end had been left, and this had been implanted into the jejunum about nine inches from its origin.

The fifth patient had been under treatment for *ankylosis of the shoulder joint*, with extreme atrophy of the deltoid muscle. She had had a tubercular infection as a child, and the joint had become involved. Mr. Devine had carried out arthroplasty by means of free transplantation of *fascia lata*. After the surfaces had been separated and shaped, a piece of fat and fascia from the *fascia lata* had been sutured around the head of the humerus. Primary healing had taken place. The movements at first had been limited on account of the atrophy of the deltoid muscle, but this muscle had subsequently hypertrophied to a considerable extent, and the patient had acquired a useful shoulder.

Mr. Devine demonstrated in the last place a case of *acute osteomyelitis* in a boy. There was great deformity of the knee joint owing to insufficient splinting. The whole shaft of the femur had suppurred, and Mr. Devine had removed the sequestrum shortly before the meeting.

Dr. Julian Smith exhibited some large *renal calculi* which had formed in the calices of a single kidney and in its ureter. The patient was a male. The other kidney had been removed previously for calculous disease.

He also demonstrated a boy who had been thrown from a horse eight months before. Soon after the accident he noticed a lump on the top of his head. The lump increased in size more rapidly during the last three months. It was removed by operation, and proved to be a *sarcoma of the cranium*. The specimen and radiograms were exhibited.

Dr. Julian Smith's third demonstration was of a *malignant growth of the rectum*.

Dr. Forbes Mackenzie showed a boy, aged 9 years, who was suffering from *actinomycosis of the neck*. The treatment consisted of exposing the tumour for periods of two minutes each once a week to X-rays. Arsenic and iodides had been given internally. The disease had lasted ten months, and the treatment had been employed since January 8, 1917.

Dr. Forbes Mackenzie showed two cases of *cavernous angioma* of the face in infants. In both cases malignant disease had been diagnosed. Radium had been employed in the treatment. Dr. Mackenzie raised the question whether radium had the effect of altering the tissue to such an extent that it assumed the appearance of a malignant growth. Microscopical sections of the angiomas were demonstrated.

He read the notes of a case of *carcinoma of the rectum* producing symptoms of obstruction. The growth had been removed by the perineal route, and with it the whole of the rectum. After the operation the patient regained perfect control over the bowel. He survived the operation by 2½ years. The specimen was exhibited.

The next patient shown had had an *ulcerative condition of the soft palate*. There was a history of syphilis, acquired 30 years before. Anti-syphilitic treatment had been applied for one month. A piece of the affected tissue had been removed for microscopical examination.

Dr. Forbes Mackenzie also exhibited a specimen from a case under the care of Dr. Young. In this case the delivery of a six months' fetus had been obstructed by distension of the urinary bladder.

Dr. J. Lee Atkinson showed a girl, aged nine years (E.), who was admitted into hospital on account of some tenderness over the appendix. She had always been a nervous child. She had a capricious appetite, suffered from constipation and from frequent headaches. There was general

malaise. An operation was performed on July 26, 1916, at which the appendix was removed. There were signs of chronic inflammation in the removed organ. The recovery was uneventful. All the symptoms had disappeared. The child had gained nearly two stone in weight and was well and strong. The appetite was voracious, the bowels were regular, and there were no headaches.

The next patient (E. T.), a female, aged 31 years, had suffered from constipation, headaches and general malaise for some years. A brownish tinge of the skin had developed, suggestive of Addison's disease. She had had two or three attacks of nausea and vomiting. The temperature, pulse-rate and respiratory rhythm were normal. There was slight tenderness over the appendix. The appendix was removed on August 10, 1916. The patient made an uneventful recovery, and all the symptoms had diminished to a considerable extent.

Dr. Atkinson also showed a girl (C. W.), aged 14 years, who had fallen ten years before and hurt her left leg. She had been crippled since the accident. The thigh was held in a position of flexion and partial adduction. There was scoliosis and lordosis. A skiagram was exhibited; it was seen from this that there had been a fracture of the neck of the femur with separation of the epiphysis. There were no signs of any tubercular affection.

Dr. John Murphy exhibited cases of (1) a *temporo-sphenoidal abscess* of aural origin, (2) a series of cases in which a radical mastoid operation had been performed, (3) a series of cases in which a radical operation for empyema of the maxillary antrum had been performed, (4) a series of foreign bodies removed, (a) from the lower end of the oesophagus (plate of teeth), and (b) from the trachea and bronchi bones by means of oesophagoscopy, tracheoscopy and bronchoscopy. In connexion with these cases Dr. Murphy gave a demonstration of the use of the bronchoscope, (5) the results of paraffin injections for nasal deformities, and (6) the results of plastic operations for aural deformities.

Dr. Francis E. McAree showed a male patient, aged 46 years, who was suffering from carcinoma of the liver and stomach. Seven years before he had noticed a lump below the right costal margin. The lump had gradually increased in size. The patient had been well except for occasional attacks of severe pain in the area of the growth until December, 1916, when he became markedly jaundiced. There had been no gastric symptoms till the end of February, 1917, when there was sudden distension and vomiting after taking solid food. The liver was very hard and nodular, and the lower edge was felt at the level of McBurney's point. There had been loss of weight and asthenia for three months. The skiagrams taken after a bismuth meal revealed "filling" defects and loss of motility. Dr. McAree called attention to the early appearance of the secondary hyptic signs, and to the very late appearance of the gastric symptoms.

Dr. McAree demonstrated a patient (G. C.), a male, aged 59, with *progressive bulbar palsy*. An alteration in the speech was first noticed 12 months before. There had been fatigue in speaking, followed by indistinct articulation. The symptoms included dysphagia, dribbling and occasional slight attacks of choking. There was an emotional disturbance by alternate laughing and crying. There were no movements of the soft palate. The elbow, knee and ankle jerks were much increased, especially on the left side, the abdominal reflex was increased on the right side, but absent on the left. There was obviously an involvement of the pyramidal tracts and of the motor nuclei. There was no disturbance of sensation. No history of a venereal infection was obtained.

Dr. McAree showed a woman (Mrs. W.), who some months before, while nursing a relative with secondary syphilis, had noticed a soreness on her finger. This soreness persisted for six weeks, but no treatment was adopted. He demonstrated a *specific ulceration of the left tonsil and a typical rash*. The patient's serum yielded a positive Wassermann reaction.

In another case, that of J. K., aged 19 years, Dr. McAree related that he had operated on him for appendicitis nine months before. Since the operation there had been intractable diarrhoea. The lymphatic glands in the groin were

enlarged and hard. There was a fading rash on the chest and arms. On the inner side of each buttock, close to the anus, there was an ulcerated area with serpiginous margins. The result of the Wassermann test had not been made known. Dr. McAree also exhibited a specimen of a complete four weeks' ovum.

Dr. Herman Lawrence exhibited cases of skin disease and of malignant disease under treatment by X-rays and by radium. These cases included *scleroderma naevi*, morphea-like rodent ulcers, etc. He also demonstrated the working of the Coolidge tube, with which he had given therapeutic doses of X-rays equivalent in the aggregate to more than 600 milliamperé-hours, without producing any alteration in the efficient working of the tube. He exhibited specimens of the *Demodex folliculorum* and cultures of *Epidermophyton inguinale*, Castellani (Dhobie itch), prepared by Captain Watson.

Dr. Edward Ryan demonstrated a female patient (O. L.), aged 37 years, who was suffering from a *cystic tumour of the pituitary body*. She had no perception of light in either eye. The pupils were widely dilated and did not respond to any stimulus. They were oval and upright. There was marked rotary nystagmus on both sides. There was double optic atrophy, more advanced on the left than on the right side. The patient was drowsy, and was mentally dull. The pulse-rate was slow, but the beat was regular. She suffered from severe frontal headache from time to time. The skin and hair was dry and the features somewhat blurred. The lips were thick. She had ceased menstruating at the age of 28 years.

Dr. Ryan also showed a girl, aged 10 years, who was suffering from choroido-retinal atrophy.

Dr. A. Normal McArthur exhibited several pathological specimens.

(1) An *anencephalic foetus*. The mother had born two children previously. The first had been born dead one month after term; the second was also still-born six weeks after term. Labour had been induced one month before term in the third pregnancy. A Wassermann test had been applied to the serum of the husband, with a negative result.

(2) A uterus, showing *fibrosis uteri*. The organ had been removed from a woman, aged 25 years, by pan-hysterectomy. She had been exsanguinated from uterine hæmorrhage, but made a good recovery after the operation. The uterus was of normal size, and was normal in appearance to the naked eye.

(3) A *bi-cornuate uterus* from a woman, aged 42 years. The uterus was invaded by fibroids; there was a large cystic ovary and a rudimentary second vagina.

(4) A segment of intestine adherent to the posterior surface of the interior wall of the uterus. The posterior wall of the uterus had undergone complete necrosis. The condition was probably due to a degenerating fibroid.

(5) A specimen from a woman, aged 64 years, on whom the operation of resection of a portion of the intestine and complete removal of the uterus and upper part of the vagina had been carried out. The patient died 12 days after the operation, probably from embolism. She had recovered from broncho-pneumonia in the interval.

Dr. McArthur also exhibited a Robert Jones' *extension splint for fractured humerus*, with two small modifications which he had found useful. A bar had been introduced to prevent the two sides from springing together when extension was being applied. The second modification consisted in the introduction of lacing for the apron to cover the fore-arm.

Dr. Thomas Murphy showed a specimen of *twin ectopic gestation*. He also exhibited a series of *fibro-myomata* of the uterus. He also showed his forceps for grasping the *fundus uteri* in abdominal operations without injuring the organ. He demonstrated a new procedure for dealing with cases of complete prolapse of the uterus.

Dr. F. L. Davies demonstrated apparatus for the application of recently introduced methods of inducing anæsthesia.

Dr. H. M. Hewlett showed a series of interesting radiograms.

Dr. W. Watkinson said, when the members assembled in the Out-patients' Department, that he had been greatly interested in the cases and specimens demonstrated and in the discussions that had taken place at the bed-side. There

was such a wealth of material that it was impossible for any member to have seen everything. He thanked the authorities of St. Vincent's Hospital for permitting the members to come there that night.

Mr. G. A. Syme seconded the vote of thanks, and expressed his appreciation of the great trouble that the members of the Staff had taken.

Dr. A. V. M. Anderson, speaking as a representative of the Alfred Hospital, supported the motion, and suggested that if the number of cases had been divided by six, it would have been as much as any one member could have digested.

Dr. Thomas Murphy, replying on behalf of the authorities of St. Vincent's Hospital, admitted that too many cases had been shown for them to appreciate the work done. He advocated that in future a larger number of cases of the kind that might be met with in ordinary practice should be shown. There was a tendency to exhibit only rare cases and cases of interest only to the person demonstrating them. He thought that it would be more interesting to a practitioner who was not a specialist to see such cases as auricular fibrillation and heart block, or in surgery the different methods of uniting fractured bones.

MEDICO-POLITICAL.

A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on March 15, 1917, Professor R. J. A. Berry, the President, in the chair.

A letter was read from the Secretary of the Friendly Societies' Association, informing the Council that the uniform medical certificates asked for by the Council were ready, and that application should be made as soon as possible for copies, in order that the new scheme might come into force on March 1, 1917. It was determined to issue a circular to members supplying full information.

The Council determined to refer the question of cypher prescriptions to the Ethical Committee for consideration and report. This matter had been raised by the Pharmaceutical Society.

A country practitioner had asked for guidance in regard to the disposal of still-born infants. The Council had submitted the matter to the Lecturer in Forensic Medicine at the Melbourne University for an opinion. The Lecturer gave it as his opinion that still-born infants must be buried in a cemetery, unless permission be obtained previously from the Board of Health for some other mode of disposal being employed. Under the *Cemeteries Act*, 1915, the Trustees of a cemetery had the power to make regulations concerning the position, depth, and other details of graves, and therefore the Trustees would possibly be within their rights in causing still-born infants to be buried in full-sized graves.

The Honorary Secretary was requested to forward a letter of sympathy to the widow of the late Lieutenant-Colonel M. L. Williams, A.A.M.C., of Bendigo, who had died of wounds received in France.

The following gentlemen were elected members of the Victorian Branch:—

Fleet-Surgeon Algernon Carter Bean, R.N., M.R.C.S.

Eng., L.R.C.P. Lond., 1896; Navy Office, Melbourne.

Vernon George Webb, M.B., Ch.B (Melb.), 1916; No. 11 Australian General Hospital, Caulfield.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending March 17, 1917:—

	Metropolitan Combined District.	Hunter River Combined District.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever	34 1	1 0	22 2	57 3
Scarlatina	32 0	0 0	29 0	61 0
Diphtheria	82 0	11 0	89 5	182 5
C'bro-Sp'l Menin.	0 1	0 0	16 4	16 5
*Pul. Tuberculosis	17 8	0 0	2 0	19 8

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending March 18, 1917:—

	Metropolitan District.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Diphtheria	44 3	41 1	85 4
Scarlatina	9 1	19 0	28 1
Enteric Fever	8 4	13 0	21 4
Pulmonary Tuberculosis	60 6	10 3	70 9
Poliomyelitis	1 —	1 —	1 —

THE HEALTH OF QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending March 17, 1917:—

Disease.	No. of Cases.
Diphtheria	40
Enteric Fever	14
Scarlatina	9
Cerebro-Spinal Meningitis	8
Erysipelas	8
Pulmonary Tuberculosis	5
Malaria	4
Ankylostomiasis	1

THE HEALTH OF SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, for the week ending March 10, 1917:—

	Adelaide.	Rest of State.	Totals.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Pertussis	2 3	22 0	24 3
Diphtheria	3 0	16 0	19 0
Morbili	0 0	10 0	10 0
Pulmonary Tuberculosis	0 4	9 4	9 8
Enteric Fever	3 1	11 3	14 4
Erysipelas	0 0	2 1	2 1
Scarlatina	0 0	1 0	1 0
C'bro-Spinal Meningitis	0 0	0 1	0 1
Puerperal Fever	0 0	0 1	0 1

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending March 17, 1917:—

Disease.	Hobart. Cases.	Country. Cases.	Whole State. Cases.
Diphtheria	4	17	21
Enteric Fever	0	1	1
Pulmonary Tuberculosis	1	1	2
Scarlatina	0	1	1

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A meeting of the Senate of the University of Sydney was held on March 5, 1917, at University Chambers, Phillip Street, Sydney.

The following degrees were conferred:—

Bachelor of Laws.—In person, G. M. Edwards and J. J. Youll.

In Master of Surgery.—*In absentia*, C. R. Wiburd, M.B. A letter was received from Professor Pollock, expressing thanks for further leave of absence granted for war service. On the recommendation of the Board of Directors of the Sydney Hospital, Dr. A. A. Aspinall was appointed temporary Surgical Tutor, *vice* Dr. E. H. Binney, resigned.

A letter was received from Mrs. Irwin Smith, offering to establish a prize in the Department of Engineering in memory of her son. It was resolved that the offer be accepted, and that a letter of thanks and of sympathy be forwarded. The question of the subject for the prize was referred to the Faculty of Science.

The death of Lieutenant-Colonel Flashman was reported by the Warden and Registrar, and it was resolved that a letter of condolence be sent to Mrs. Flashman, expressing appreciation of his services to the University.

The application of Professor J. Douglas Stewart for leave of absence for military duty was granted, and the following arrangements proposed by him for carrying out the work of his department were approved:—Dr. S. Dodd, Lecturer in Veterinary Pathology and Bacteriology, to be Acting Professor, and Mr. F. Whitehouse, B.V.Sc., to be temporary Lecturer and Demonstrator in Senior Anatomy and Materia Medica.

Mrs. Dwyer moved the following motion standing in her name:—

That a Chair of Domestic Science be established in the University of Sydney.

Professor Wilson moved the following amendment:—

That the matter be referred to the Professorial Board for consideration and report in connexion with the subject of the future development of the University studies already referred to the Board.

The amendment, upon being put to the meeting, was carried.

Lists of Members.

Our attention has been called to two omissions from the lists of members of the six Branches of the British Medical Association in Australia, which were published in our issue of February 17th, 1917. It is exceedingly difficult for the Honorary Secretaries of the Branches to exclude mistakes from these lists, although every care is taken. Members are therefore requested to notify either the Honorary Secretary of the Branch concerned, or the Editor of *The Medical Journal of Australia*, if any errors are discovered. Through inadvertence the names of Dr. W. E. Warren of Kurildale, late of Friesland, Queensland; and of Dr. E. R. Sutton, late of Elizabeth-street, Sydney (now of Melbourne), have been omitted from the lists of members of the Queensland and New South Wales Branches respectively. Dr. Sutton was transferred from the Victorian Branch on February 1, 1917.

Naval and Military.

Two lists of casualties, the 281st and 282nd, have been issued on March 22 and 26, 1917, respectively. These lists contain the names of 1847 officers and men, of whom 400 are dead. The sick number 583. Only one medical man is mentioned in these lists. Captain D. J. Glissan is reported to be ill in hospital.

We have received a copy of the regulations for admission into and particulars of service in, the Royal Australian Naval Medical Service. These regulations will take effect on April 1, 1917. We propose to publish them as soon as the requisite space can be found.

The following appointments have been announced in the Commonwealth of Australia Gazette, No. 44, of March 22nd, 1917:—

Army Medical Corps.

To be Captains—

Honorary Major C. A. Stewart, Australian Army Medical Corps Reserve. Dated 7th March, 1917.

Honorary Captain R. M. Allan, Australian Army Medical Corps Reserve. Dated 4th February, 1917.

Honorary Captain A. W. Connolly, Australian Army Medical Corps Reserve. Dated 16th February, 1917.

John Joseph Power. Dated 28th June, 1915. (This cancels the notification respecting the date of appointment of this officer which appeared on page 1618 of the Commonwealth of Australia Gazette, No. 95, of 21st August, 1915.)

John Whyte Grieve. Dated 17th February, 1917.

Edward Augustus Spowers and Leslie Thomas Allsop. Dated 26th February, 1917.

Gilbert Charrington Wellisch,
Neville Graham Sutton,

Alexander Paterson Murphy,
John James Campbell Lamrock, and
Clyde Isaac Davis. Dated 1st March, 1917.

First Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captain—

Robert Marshall Allan. Dated 11th September, 1914.

(This cancels the notification respecting the date of appointment of this officer which appeared on page 3470 of *Commonwealth of Australia Gazette*, No. 190, of 28th December, 1916.)

Second Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captains—

David Kerr,
Frederick Challands,
George Arthur Buchanan,
Ralph Osmund Williams,
Norman Dowling, and
Arthur Paul Gillespie

Robert Norman Scott Good. Dated 5th February, 1917.

Honorary Captain W. J. Bird is transferred to Australian Army Medical Corps Reserve, 3rd Military District, with seniority as from date of transfer. Dated 1st March, 1917.

Honorary Captain H. R. Letcher is transferred to Australian Army Medical Corps Reserve, 4th Military District, with seniority as from date of transfer. Dated 27th February, 1917.

The services of Honorary Lieutenant J. A. B. Walker are dispensed with under the provisions of Australian Military Regulation 158 (k).

3rd Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captain—

William John Trehwella. Dated 28th September, 1915.

Honorary Captain W. J. Bird is transferred from Australian Army Medical Corps Reserve, 2nd Military District, with seniority as from date of transfer. Dated 1st March, 1917.

4th Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captain—

Patrick William Rice. Dated 29th September, 1915.
Samuel Lloyd Corry. Dated 21st February, 1917.

Honorary Captain H. R. Letcher is transferred from Australian Army Medical Corps Reserve, 2nd Military District, with seniority as from date of transfer. Dated 27th February, 1917.

5th Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captain—

Robert Macfarlane Mitchell. Dated 1st January, 1917.

To be Honorary Captains—

Charles Herbert Hill,
William Johnson Langley,
William Theodore Hodge,
Anthony Joseph James Triado,
John Hume,
Dodwell Browne, and
William Douglas Buchanan-Yuille. Dated 1st February, 1917.

The resignation of Captain A. R. Haynes of his commission is accepted. Dated 10th October, 1916.

6th Military District.

Australian Army Medical Corps Reserve.

To be Honorary Captain—

John Henry Raymond McCutcheon. Dated 1st March, 1917.

The resignation of Honorary Lieutenant R. R. Holmes of his commission is accepted. Dated 1st March, 1917.

His Excellency the Governor-General has been pleased to approve of the under-mentioned officers, who have served in the Australian Imperial Force as Commissioned Officers, having the rank held by them in the Australian Imperial

Force confirmed as honorary rank in the Australian Military Forces:—

2nd Military District.

To be Honorary Lieutenant-Colonel—
Major W. C. Grey, Australian Army Medical Corps.
Dated 1st January, 1916.

To be Honorary Majors—
Captains R. A. P. Waugh and W. T. Newton, Australian Army Medical Corps. Dated 1st January, 1916.

Captain S. Kay, Australian Army Medical Corps.
Dated 6th February, 1916.

3rd Military District.

To be Honorary Lieutenant-Colonel—
Captain J. A. H. Sherwin, Australian Army Medical Corps. Dated 25th February, 1916.

To be Honorary Majors—
Quartermaster and Honorary Captain C. Morley, Australian Army Medical Corps (Permanent Services). Dated 22nd November, 1915.

Quartermaster and Honorary Lieutenant O. J. Lawson, Australian Army Medical Corps. Dated 16th May, 1916.

4th Military District.

To be Honorary Major—
Captain C. Bollen, Australian Army Medical Corps.
Dated 10th August, 1915.

5th Military District.

To be Honorary Lieutenant-Colonel—
Captain J. E. F. Stewart, Unattached List. Dated 19th October, 1914.

The Secretary of the Queensland Branch of the British Medical Association has received the following letter:—

Dear Sir,—Since my return it has been my intention to write this letter several times. Whilst I was in Egypt and France on service, I had a locum tenens looking after my practice. He left me some months before my return, and my attorneys were unable to get another. It was then that my two confrères here, Drs. Williams and Chenoweth, stepped in and did my contract work for me, allowing my agents to bank the amounts to my credit. I think it would be amiss of me if I did not place this on record with your Association. It certainly stands in contrast to what many of my fellow-soldiers have found on their return. I would be glad if you would place this letter before the Council.

Yours sincerely,

(Sgd.) STUART KAY.

Italka, Brisbane-street, Mackay,

18/3/17.

Special Correspondence.

(By Our Special Correspondent.)

LONDON LETTER.

The Effect of the War on Crime and Drunkenness.

The Police Commissioners' Annual Report, which was published on September 25, 1916, bears testimony to the marked effect which the war has had in diminishing crime and lessening the number of convictions due to alcohol. The number of prisoners received under sentence was only 64,160, compared with 114,283 in 1914—a decrease of 50,123. The year 1904 saw the largest number of sentenced criminals—197,941—and the total per 100,000 of the population of England and Wales has fallen from 586 in that year to 159 in 1915. Three main causes seem to have contributed to the great decrease in the prison population: (1) The enlistment of many habitual petty offenders; (2) the restrictive orders issued by the Liquor Control Board and those made by the justices and military authorities; and (3) the great demand for labour, rendering employment easy and well paid, and resulting in ability to pay fines. The number of prisoners received of military age fell from 61,739 in 1914 to 19,169 during the year under review. "One of the notable effects of the war on the prison population

has been that the receptions are now for the most part confined to the physically and mentally weak." To ascertain the effect of the war upon women convicted for drunkenness, the Lady Inspector of Prisons inquired respecting women sent to Holloway for this offence. She found that the average convictions per individual for 1913 (2.6) rose to slightly over five in 1915. The Commissioners comment on the decline in the number of habitual drunkards committed to inebriate reformatories—95 in 1913 and only nine in 1915. This is due in part to the war, but the failure of the Inebriates Act must, they say, be admitted. Though the figures are inconclusive as furnishing proof of any increase or otherwise in drinking among women at the present time, they show, if the same proportion holds as at Holloway, not only a considerable decrease in the total receptions into prison, but a decrease of over 60% in the individual's responsibility for the convictions. If medical observation shows that mental causes enter into the history of the confirmed and hopeless inebriate, the Mental Deficiency Act now provides the opportunities for dealing otherwise with repeated drunkenness than by the useless and senseless methods hitherto prevailing of repeated sentences to short terms of ordinary imprisonment. This, the Commissioners declare, affords no cure; perhaps only an encouragement. It is unscientific in principle and further degrades the subject, man or woman. It is hoped to complete a scheme in the near future by utilizing certain prisons as centres for the collection of all suitable cases of social disease to undergo treatment according to the latest scientific discoveries.

Life Assurance and War Finances.

On November 27, 1916, Mr. S. G. Warner, President of the Institute of Actuaries, related some interesting facts relating to life insurance and annuity business in Great Britain since the beginning of the war.

War claims amounting to over £7,500,000 had been paid, and £75,000,000 had been invested in Government securities. Securities of the face value of over £46,000,000 had also been sold or lent to the Treasury. Before the Treasury schemes had appeared large blocks of American securities had been sold by the life assurance companies on open market, with a view to maintaining the rate of exchange, the total amount being not less than £20,000,000. Friendly societies had invested in War Loan Securities about £1,700,000. It had been stated in the House of Commons that up to the end of October, 1916, approximately 44,500,000 £1 certificates had been issued, the scheme having only been inaugurated on February 22, 1916. For the first three and a half months investment in these certificates was forbidden to persons with annual incomes exceeding £300, and during that period the issue was about 4,275,000 £1 certificates. Then the income limit was removed, and since June 10, 1916, fifteen and a quarter million of £1 certificates had been issued in the maximum batches of £500, a clear proof that classes other than that of the industrial worker had availed themselves of the scheme. Small investors also were being attracted, for in the same period about an equal number of the certificates were issued in sets of from one to 25. Referring to the National debt, Mr. Warner said if we accepted the Chancellor of Exchequer's estimate of a net debt of 2,640 millions in 1917, we should stand, as compared with 1815, in a position twice as favourable in relation to capital, and one and four-fifths times as favourable in relation to income.

Restrictions in Regard to Opium and Cocaine.

By an Order dated December 5, 1916, some amendments have been made in the Defence of the Realm Regulation relating to cocaine and opium, of which the following are the most important:—

1. Power is given to the Secretary of State to issue licenses for the manufacture of cocaine in this country. Any person manufacturing or carrying on any process in the manufacture of cocaine without a license will be liable to a penalty.

2. A medical practitioner who gives a prescription for the supply of cocaine otherwise than in accordance with the conditions laid down in the Regulation is made liable to a penalty.

3. Every article containing cocaine must be marked with the amount and percentage of cocaine contained in it.

4. Power is given to the Secretary of State to direct that any person authorized under the Regulation to purchase cocaine or opium who is convicted of an offence against the Regulation or against the Proclamations regulating the import or export of cocaine or opium shall cease to be an "authorized person."

5. The authorization in the case of registered chemists and druggists is limited to persons, firms, or bodies corporate who carry on the retail business of a chemist and druggist.

Correspondence.

COMPULSORY MEDICAL ENLISTMENT.

Sir,—For some time back your columns have been occupied on the subject of compulsory medical enlistment, with what effect I do not know. I am an elderly practitioner, acting as locum to enable a young man to go on active service. He went, knowing it would be a pecuniary loss, but his patriotism outweighed the monetary disadvantage. He went early in the war, and I find that my earnings are a little more than one-third of his former income. If sickness has been up to the average it is clear two-thirds have been absorbed by the other men in this town. A fact like this prevents men from volunteering, and patriotic feelings are damped by our selfishness. Practitioners of military age and with physical fitness can be divided into two classes: First, the men who would like to go, but are deterred by the probable loss of income, only to be met by military pay, and second, those who see the chance of a lifetime, and find that owing to men's absence their income has mounted up. What is required is a scheme to be devised to meet the case of these two classes, so that the man who goes to the war shall not lose, and the man who remains shall not gain. It will be hard to conjure such a scheme. But it is hard for a man from patriotic reasons to yield up income and home to endure hardships in France and to risk his life on behalf of a man who stays at home, sleeps on a feather bed and enjoys an increasing bank account. How to make the latter feel an equal hardship and bear an equal loss is a difficult problem to solve. I cannot suggest a clue.

Yours, etc.,

"SENIOR G.P."

LODGE PRACTICE IN VICTORIA.

Sir,—There appears to be a belief among members of the Victorian Branch, B.M.A., that it is the war which has prevented a settlement of their Lodge grievances. May I point out that on September 7, 1912—nearly two years before the war—the leading article of *The Australian Medical Journal*, after referring to the completion of three months' organization work, continued:—"The question of moment is 'What next?' It would be more than a pity if the enthusiasm of the younger members and the hopefulness of the older observers should be allowed to evaporate by a prolonged interlude of marking time. It would indeed be a futile undertaking to march a people up to the promised land and leave them looking over the fence." Six weeks later, in a second leader, are the words:—"What the profession in Victoria has to ask itself now is: 'What are we going to insist upon?' And the sooner it is decided either by special conference of delegates or other means, the better for organization." On June 27, 1914—still before the war and nearly two years after the foregoing quotations—the last issue of the *Journal* contained this reminder: "In Victoria for the past two years there has been a mysterious something called organization going forward, and nobody yet seems to know what the profession wants. There have been conferences and there are to be further conferences, and these will result in other conferences, and absolutely no point of decision comes about. The last word in this column to the profession in Victoria is that valuable time—nay, invaluable time—is being lost, and while those behind cry 'forward' and those in front cry 'back,' the real position is that of a standstill."

The plain fact is that in Victoria the Lodge question has remained unsettled through hopelessly bad leadership. It

is to be desired that the militant party of to-day will see to it that this mistake is not repeated.

Yours, etc.,

"HSTORICUS."

ENTERIC FEVER AND SOIL CONTAMINATION.

Sir,—Referring to the above subject, and the letters which have appeared on it in various issues of *The Medical Journal of Australia*, the following may be of some interest.

Some ten years ago I was Medical Officer of Health (as well as District Surgeon) for the District of Umlazi in Natal, my headquarters being at Pinetown, about 19 miles from Durban, on the main line to Pietermaritzburg. While I was there, a somewhat severe epidemic of enteric (with about 25 cases and several deaths) occurred at Pinetown, and on investigating the same I found that the families attacked all lived on a certain ridge, about half a mile to the South-west of the main town.

This ridge was in course of settlement, many small villas and houses being erected, though others had been there for some time, and a good deal of turning-up of soil was done in the way of making gardens, foundations, etc.

Investigation also showed that this particular ridge had been a site of some of the military hospitals in the late South African war, and also for the military hospitals used during one of the late Zulu wars, somewhere about 1881.

Having excluded (as I thought) all other sources, I reported to the Chief Health Officer to the Colony that I considered that the outbreak had something to do with turning up soil which had probably been contaminated from the military hospitals in question, which tradition stated had had a large number of enteric cases in them. This opinion was considered a feasible one.

According to various authorities, the bacillus concerned has considerable resisting powers in regard to temperature, soil, and ordinary water. I believe it is allowed that they will live at least six months in the upper layers of the soil, but possibly they may live longer.

Might it not be possible that certain virile strains of the bacilli might survive and increase for an unknown length of time, much as the fresh-water sharks of the Nicaraguan Lakes are, evidently the surviving descendants of the salt-water sharks which were imprisoned in various tracts of water which were raised above sea level by some earth disturbance.

The epidemic referred to was very closely investigated, and the decision was that the turning up of contaminated soil was probably the cause. Of course, other hypotheses will occur, but the one accepted seemed the most likely.

Yours, etc.,

J. BOOTH-CLARKSON,

D.P.H. & D.T.M.H. (Camb.), etc.; A.M.O.H., H.R.C.D.
Hunter River Combined District,
Newcastle.

20th March, 1917.

THE ROLL OF HONOUR.

Sir,—Under the heading, "Roll of Honour," the retiring President is to move at the annual meeting¹ "that . . . the names of all members who have enlisted . . . shall be enrolled by the Council in a suitable book to be preserved in the Library of the Association." Surely the Roll of Honour should not be hidden away in such manner, but placed in a position of honour, where it may be seen by members for all time! It would be as reasonable to suggest that the photographs of members of the Council, which very properly adorn the walls of our meeting room, should be placed in an album and preserved in the Library of the Association.

Yours, etc.,

A.A.M.C.

24.3.1917.

Dr. Leonard Redmond, of Charters Towers, Queensland, writes to call our attention to his election as alderman, representing No. 4 Ward of Charters Towers. There were

¹ Presumably of the New South Wales Branch of the British Medical Association.—Ed.

five candidates, and Dr. Redmond secured 250 votes, while the other candidates secured 247, 236, 197, and 177 respectively. He regards his election as a victory over the management of the local Lodge and Hospital, from which he has been excluded for 30 years.

Books Received.

DISEASES OF THE SKIN, by Richard L. Sutton, M.D., 1916. St. Louis: C. V. Mosby Company; Melbourne: Stirling & Company; Royal Soc., pp. 693, with 8 coloured plates and 693 illustrations. Price, 30s.
FRACTURES AND DISLOCATIONS: DIAGNOSIS AND TREATMENT, by Miller E. Preston, A.B., M.D., with a Chapter on Röntgenology by H. G. Stover, M.D.; 1915. St. Louis: C. V. Mosby Company; Melbourne: Stirling & Company; Royal Soc., pp. 813, with 860 illustrations. Price, 30s.
DISEASES OF THE DIGESTIVE TRACT AND THEIR TREATMENT, by A. Everett Austin, A.M., M.D., 1916. St. Louis: C. V. Mosby Company; Melbourne: Stirling & Company; Royal Soc., pp. 532, with 75 illustrations and 10 coloured plates. Price, 25s.

Medical Appointments.

Dr. Joseph English, J.P., has been appointed Deputy Licensing Magistrate of the Licensing Court in the District of Yass, to act during the absence of the Licensing Magistrate, for a period not exceeding six months.

Dr. Ralph Athelstone Noble has been appointed, on probation for twelve months from December 15, 1916, as Junior Assistant Medical Officer, Lunacy Department, New South Wales.

The appointment of Dr. Edward Angas Johnson as Deputy Inspector-General of Hospitals of South Australia, during the temporary absence of Dr. Bedlington Howell Morris, the Inspector-General of Hospitals, has been terminated.

Dr. Ida Gertrude Margaret Halley has resigned the position of Officer of Health in South Australia.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

Brisbane Hospital, Junior Resident Medical Officers.
 Herberton Hospital, Surgeon.

Medical Appointments.

IMPORTANT NOTICE

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA.	
(Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australasian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
QUEENSLAND.	
(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute

Branch.	APPOINTMENTS.
SOUTH AUSTRALIA.	
(Hon. Sec., 8 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
WESTERN AUSTRALIA.	
(Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES.	
(Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wall-send.
NEW ZEALAND: WELLINGTON DIVISION.	
(Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

- Apr. 3.—N.S.W. Branch, B.M.A., Council (Election of Officers and appointment of Standing Committees).
- Apr. 4.—Vic. Branch, B.M.A., Branch.
- Apr. 10.—N.S.W. Branch, B.M.A., Council (Quarterly).
- Apr. 10.—Tas. Branch, B.M.A., Council and Branch.
- Apr. 12.—Vic. Branch, B.M.A., Council.
- Apr. 13.—N.S.W. Branch, B.M.A., Clinical.
- Apr. 13.—Q. Branch, B.M.A., Branch.
- Apr. 14.—S. Aust. Branch, B.M.A., Council.
- Apr. 17.—N.S.W. Branch, B.M.A., Executive and Finance Committee; Ethics Committee.
- Apr. 18.—W. Aust. Branch, B.M.A., General.
- Apr. 18.—North Eastern Med. Assoc. (N.S.W.), Annual.
- Apr. 19.—City Med. Assoc. (N.S.W.).
- Apr. 20.—Q. Branch, B.M.A., Council.
- Apr. 20.—Eastern Suburbs Med. Assoc. (N.S.W.).
- Apr. 21.—Northern Suburbs Med. Assoc. (N.S.W.), Annual.
- Apr. 24.—N.S.W. Branch, B.M.A., Med. Politics Committee; Organization and Science Committee.
- Apr. 25.—Vic. Branch, B.M.A., Council.
- Apr. 27.—N.S.W. Branch, B.M.A., Branch (Ordinary).
- Apr. 27.—S. Aust. Branch, B.M.A., Branch.

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